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Opioid Crisis: Causes, Impacts, and Response Strategies

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Abstract:

The opioid crisis has become a significant international public health crisis fueled by complicated interactions between the medical profession, pharmaceutical marketing, regulatory failure, and socioeconomic vulnerability. This literature-based narrative review addresses the causes, effects, and response measures related to opioid misuse and opioid use disorder. Evidence demonstrates that increased opioid prescribing for the management of pain, manufacturing of drugs with heavy commercial promotion and inadequately established surveillance systems contributed to mass exposure and dependence. Subsequent transitions to heroin and extremely powerful synthetic opioid drugs compounded the overdose deaths and the burden on the health system. The review integrates the findings about major health consequences, such as overdose mortality, chronic medical complications, psychiatric disturbance, infectious disease transmission, and wider effects on society in particular families, communities, labor markets, and criminal justice systems. Policy and practice responses are reviewed on the areas of prescribing regulation, prescription monitoring, medication-assisted treatment, naloxone distribution, harm reduction services, and community-based interventions. The growing body of research regularly supports the use of multi-level, comprehensive frameworks involving prevention, treatment, harm reduction, and social support as opposed to isolated approaches. Effective long term response requires increasing access to successful evidence based treatment, building out public health infrastructure, stigma reduction and also addressing structural factors of risk. A guided and cohesive approach to opioid-related morbidity and mortality remains fundamental to decreasing opioid-related morbidity and mortality in a sustainable manner.

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Introduction

The opioid crisis is one of the greatest and most complicated 21st century public health emergencies. Over the last three decades an increasing number of opioid medications, first marketed for control of pain, are available and being used in general, leading to increasing misuse, dependence, overdose and mortality in several regions of the world. Although the crisis has been best documented in North America, especially in the United States and Canada, opioid-related harms are increasingly being seen as a global phenomenon of concerned high-income and low- and middle-income countries (World Health Organization [WHO], 2021). Opioids include prescription pain relievers, like oxycodone, hydrocodone, morphine, and fentanyl, which are addictive drugs, and illegitimate product substances such as heroin and synthetic opioids that are illegally manufactured. These substances act on opioid receptors in the brain to produce analgesia and euphoria but also convey a significant potential of tolerance, dependence and respiratory depression when abused (Volume and McLellan, 2016). Beginning in the 1990s, a confluence of factors - including shifts in pain treatment philosophy, aggressive marketing of pharma companies and lack of regulatory oversight - led to spectacular increases in the prescription of opioids. Subsequent waves of heroin consumption and synthetic opioid growth only exacerbated the epidemic (Kolodny et al., 2015).

Scholarly literature is identifying opioid crisis as a complex multidimensional phenomenon that is under the influence of biomedical, behavioral, structural and socioeconomic factors. It is therefore not sufficient to interpret the epidemic from an individual level and personal perspective of substance misuse. Instead, multifaceted contributions such as prescribing behaviors, health policy deficits, social inequality, mental health comorbidities and the illicit drug market dynamics are the focus of more current studies (Dasgupta, Beletsky, & Ciccarone, 2018). This narrative review reviews the current literature on the opioid crisis and focuses on its historical evolution, driving factors and health and social consequences, and evidence-based response strategies. The idea is to offer an integrated conceptual and empirical overview appropriate both for academic and policy oriented audiences.

Historical Evolution of the Opioid Crisis

Understanding the opioid crisis needs a historically grounded analysis of the convergence of medical practice, pharmaceutical development, and policy decision in the course of time. The literature often refers to the epidemic as occurring in three overlapping waves that are the prescription opioid wave, the heroin wave, and the synthetic opioid wave (Centers for Disease Control and Prevention [CDC], 2023; Ciccarone, 2019). As drugs and treatment The first wave started in the early to mid-1990s when opioid prescribing rose sharply as a result of a paradigm shift in the treatment of pain. Pain began to be encouraged as the "fifth vital sign," and physicians were urged to be more aggressive in treating it. During this time period, drug companies pushed extended release versions of opioids as safe and effective in the treatment of chronic non-cancer pain, regularly minimizing the danger of addiction. One well-known example is that of the drug OxyContin, which was sold with claims about low potential of addiction which later turned out to be false (Kolodny et al., 2015). As a result, the rate of prescribing opioids rose dramatically, which in turn is mirrored by increments in misuse and overdose deaths.

Income from the penitence is an epidemiological data confirms extent of prescribing climbing for this era. In the United States, the prescribing of opiates has almost quadrupled between 1999 and 2010 and is not accompanied by an increase in the amount of pain in the population (CDC, 2023). This mismatch suggested that prescribing practices were being motivated by

issues beyond the need for the ICDs alone. Studies also documented regional variation of prescribing which indicated provider behaviour and local medical culture was also a major factor in opioid availability (Guy et al., 2017). The second wave occurred around 2010 and is characterized by an increase in heroin use and heroin-related overdose death usage. As the availability of prescription opioids was regulated, some opioid dependent figures moved to heroin because of its cheaper prices and ease of accessibility. Cicero, Ellis, and Surratt (2014) have determined that a large percentage of people in treatment for opioid use disorder reported starting misuse with prescription opioids and then switching to heroin. This substitution effect showed how supply side controls by themselves did ever change the drug use patterns instead of obliterating risk.

The third wave which started around 2013 has been caused by synthetic opioids - particularly by the illicitly made fentanyl and its analogues. These substances are far more potent than morphine or heroin and are mixing into other drugs without users even realizing it was a factor; this drastically raised the risk of overdose. Synthetic opioids are responsible for most of the opioid-related overdose fatalities in several countries (Ciccarone, 2019). Their high potency, low cost of production, and ease of transport have transformed the illicit drug markets and made the intervention difficult. Historical analyses imprint the opioid crisis advantage reference as not once in a while but like a courtroom technique shaped by interacting medical, commercial, regulatory, and illicit systems. Each wave has reflected unintended consequences of prior responses, leading to the need for comprehensive and anticipatory policy responses (Dasgupta et al., 2018).

Drivers and Root Causes of Opioid Misuse

The literature states various interrelated drivers of opioid misuse and dependence. These drivers can be broken down into medical and prescribing factors, pharmaceutical industry influence, weaknesses in the regulatory system and the system-level, and socioeconomic and psycho-social factors. A constant theme of the studies is that there is not one cause for crisis, rather it comes from multiple vulnerabilities in systems and populations. One of the most commonly cited driving force is opioid overprescribing. Volkow and McLellan (2016) claim that increased prescribing for chronic non-cancer pain occurred before there was strong evidence to support the long-term effectiveness and safety of opioids. Clinical trials supporting opioid use often were short term, whereas real-world prescribing was months or years. This gap in evidence played an important role in widespread exposure and an increased number of people at risk for misuse and addiction. Meta-analytic reviews indicate that treatment with an opioid over a long period of time is linked with increased risks of addiction and overdose, particularly when dosages are at higher levels (Chou et al., 2015).

Pharmaceutical marketing practices played an important role in amplifying it. Historical investigations and legal cases have noted that some manufacturers sponsored educational programs, sponsored important opinion leaders and promoted promotional materials that downplayed the risk of addiction and placed a focus on the benefits (Van Zee, 2009). These strategies affected physician prescribing behavior as well as patient expectations. Kolodny et al. (2015) suggest that the commercial messaging helped to change clinical norms regarding pain treatment, and perpetuated a culture of opioid abuse outside of specifically selected indications. There were also regulatory and monitoring weaknesses. Early prescription drug monitoring efforts were fragmented or nonexistent and did not support the extent of potential identifying high risk prescribing or "doctor shopping." Inconsistent instructions and lack of prescriber training in addiction medicine further added to the problem (Guy et al.,

2017). Even where there were guidelines, their implementation was patchy and attempts at enforcement were small-scale.

Without focusing on healthcare systems, socioeconomic conditions have a strong relationship with opioid misuse risk. Research connects opioid-related harms with joblessness, poverty, housing and social disintegration. Case and Deaton (2015) coined the term "deaths of despair", to describe the relationship between economic and social distress and rising mortality from drugs, alcohol and suicide. Subsequent analyses determined that areas with the highest opioid mortality rates were often those with industrial decline and disruption in the labour market (Dasgupta et al., 2018). It is also a major factor that hinders much else, namely the presence of psychiatric comorbidity. Individuals with depression, anxiety disorders, post-traumatic stress disorder, and other mental health diagnosed conditions are at high risk of overuse of opioids and opioid use disorder (OUD). Opioids may be used not just for physical pain, but also for emotional suffering and it reinforces maladaptive coping patterns (Volkow, Jones, Einstein, & Wargo, 2019). Trauma experience and negative childhood experiences are also systematically linked to vulnerability to substance misuse at a later age.

Cultural beliefs about pain and pain medication also influence the behavior. In certain aspects of health care, pharmacological intervention for rapid relief is considered more important than multimodal or non-pharmacologic interventions. This expectation can cause clinical pressure to prescribe opioids when the alternatives may be better. Studies of patient satisfaction measures have also indicated that perceived pressure to treat pain aggressively contributed to prescribing decisions (Van Zee, 2009). Overall, the literature lends support to the concept of a systems model of causation: medical practice patterns, activity of industries, holes in regulatory policy, and social determinants interact to result in risk environments. Effective response strategies therefore need to be multi-level intervention rather than residing in isolated measures rather than being isolated.

Health and Public Health Impacts of the Opioid Crisis

The opioid crisis has had profound and measurable effects on population health, healthcare systems and mortality patterns. However, the most visible and one of the most widely reported results is the dramatic increase in opioid-related overdose deaths. However, the wider health burden goes well beyond mortality to include chronic disease complications, worsening mental health, transmission of infectious disease, or continued strain on emergency and primary care. The literature has consistently described opioid misuse as posing a direct threat to a clinical outcome as well as a multiplier of other health risks. Overdose death is the key epidemiologic metric that is used to monitor the extent of the opioid epidemic. In the United States, overdose deaths involving opioids have more than six-fold in the years between 1999 and the beginning of the 2020s and synthetic opioids-especially illegally manufactured fentanyl-are responsible for the most recent increase (Centers for Disease Control and Prevention [CDC], 2023). Similar increases have been recorded by marked degrees in Canada and parts of Europe [World Health Organization [WHO], 2021]. Synthetic opioids are especially dangerous because they are particularly potent, radically unpredictable in their concentration within the illicit supply, and they are mixed with other substances quite frequently, which makes fatal respiratory depression even more likely (Ciccarone, 2019).

Clinical literature describes the cause of overdose in terms of opioid induced respiratory depression. Opioids inhibit the brain stem respiratory centers, decreasing the rate of breathing and oxygenation. Increases with high dosages, concurrent use of other sedatives

such as benzodiazepines or alcohol, as well as lowered tolerance following periods of abstinence (Volkow, Jones, Einstein, & Wargo, 2019). Post-incarceration and post-detoxification periods are particularly high-risk time periods because the physiological tolerance decreases while behavioral patterns may continue. Beyond the fatal overdoses, the nonfatal overdoses result in a significant morbidity and a healthcare utilization. Hence, survivors may have hypoxic brain injury, mental impairment and neurological injury that persist for a long time. Emergency departments in especially affected regions are reporting sustained increased visits related to overdoses which tax acute care capacity (Hasegawa et al., 2014). Recurrent overdoses are common, rather than acute reversal, not getting people linked to treatment, indicating that there are not sufficient linkages w/ treatment to interrupt risk trajectories.

Opioid misuse is also shown to be related to a number of chronic health complications. Long-term use of opioid can cause a pattern of dysfunction to the endocrine system, gastrointestinal disorders, hypersensitivity to pain (opioid-induced hyperalgesia), and immune suppression [Chou et al., 2015]. Often individuals with opioid use disorder (OUD) will present with comorbid mental health disorders such as depression and anxiety which are associated with a struggle for treatment as well as a poor prognosis (Volkow & McLellan, 2016). Partnerships need to give dual diagnosis cases models of integrated care, but in many cases the services are fragmented. Transmission of infectious diseases is another large public health consequence, especially if the opioids are injected. Injection drug use is a known risk factor of HIV, hepatitis C virus (HCV), and some bacterial infections, including endocarditis and skin and soft tissue infections. Several studies report localized outbreaks of HIV and HCV that are associated with inject opioid use in communities lacking access to harm reduction services (Dasgupta, Beletsky, & Ciccarone, 2018). Increases in opiates injection have also been linked to an increase in infective endocarditis requiring expensive surgery (Wurcel et al., 2016).

Effects of maternal and neonatal health are now better documented. Increasing opioid use among pregnant women has led to increasing cases of neonatal abstinence syndrome (NAS), a withdrawal syndrome in newborns who are exposed to opioids in the womb. Incidence of NAS rose significantly in the 2000s and 2010s, resulting in longer duration of hospitalization in the neonatal unit and higher healthcare costs (Patrick et al., 2015). There is evidence of the safety of medication-assisted treatment during pregnancy in comparison to treatment of opioid dependence without medication and access is uneven. From a systems perspective, the opioid crisis has compelled healthcare systems to trend quickly. Demand for addiction treatment and overdose response, infectious diseases and mental health services have grown at the same time. Workforce shortages in addiction medicine and behavioral health create condom provision limitations in numerous areas (Volkow et al., 2019). The literature is clear that the incidence of opioid-related harm is not contained in Addiction specialty settings but is divided among emergency medicine, primary care medical, obstetrics, psychiatry, and infectious disease practice. Public health scholars increasingly argue that the opioid crisis should be conceptualized as a syndemic - an interacting set of epidemics involving issues of substance use, mental illness, infectious disease and social vulnerability (Dasgupta et al., 2018). This framing provides for integrated surveillance and intervention models instead of siloed approaches to address specific diseases.

Social and Economic Consequences

While clinical and epidemiological effects of the opioid crisis are severe, the literature shows equally significant social and economic consequences to the opioid crisis. Opioid misuse

impacts families, labour markets, the criminal justice system, as well as community stability. Researchers repeatedly stress that opioid-related harm spreads itself through social networks and institutions, which leads to multilevel disruption both further afield and beyond single users. At the family level, opioid dependence has been found to be related to relationship strain, domestic conflict, and disruption of caregiving. Qualitative studies report on the patterns of financial depletion, mistrust, and emotional distress among family members of people with OUD (Orford, Velleman, Copello, Templeton, & Ibanga, 2010). Children in affected households are at increased risks for neglect, instability, and adverse childhood experiences which in and of themselves are predictors of subsequent mental health and substance use problems. Foster care systems in regions of high opioid misuse by parents have reported increased caseloads related to parental opioid misuse (Patrick, Davis, Lehmann, & Cooper, 2015).

Stigma and social exclusion themes are very constant in the literature. Individuals with OUD often experience negative stereotypes, discrimination in the healthcare setting, and social marginalization. Stigma decreases treatment-seeking behavior, undermines therapeutic relationships, and also influences policy preferences to punitive rather than therapeutic solutions (Livingston, Milne, Fang, & Amari, 2012). Studies show that stigmatizing attitudes are found not only in the general public, but also among some healthcare professionals which affects quality of care. Community through increased strain on social services, emergency response and related public safety infrastructure. In regions where there is high overdose rates often times there is pressure on emergency medical services, morgues and public health departments (CDC, 2023). Public use of drugs and discarded drug equipment contribute to community perceptions of their neighbourhoods not being safe or well order, sometimes heightening political pressure for enforcement centre approaches as opposed to harm reduction (Dasgupta et al, 2018).

The relationship between opioids and crime is complex and two-fold. Substance dependence may lead to greater involvement in acquisitive crime in order to pay for drug use and drug market enforcement may lead to greater numbers of incarceration with substance use disorders. However, the literature warns against easy cause-and-effect claims. Many drug arrests involving opioids are for possession, not for violent crime, and criminalization can make it worse by interrupting treatment and making it more likely that people will overdose after they get out of prison (Binswanger et al., 2013). Diversion programs and drug courts that send people to treatment rather than jail have more beneficial outcomes than purely punitive programs. Economic analyses estimate that the opioid crisis takes a huge toll on society in terms of healthcare spending, lost productivity, disability, and criminal justice involvement. Florence, Luo, Xu and Zhou (2016), estimated the economic burden of prescription opioid misuse in the United States alone at tens of billions of dollars per year, in direct medical costs and indirect losses to productivity. Updated analyses using synthetic opioid mortality put even higher totals for the recent years (CDC, 2023).

The labor market effects are studied more and more. Regions with higher rates of prescribing and misuse of opiates have lower labor force participation, especially for prime age men (Krueger, 2017). Chronic opioid use can result in lower functional capacity and employability but also unemployment and job insecurity can contribute to an increased risk of misuse which can create a feedback loop. This two-way relationship provides even greater appreciation to address the structural economic factors in addition to the clinical treatment. Housing instability and homelessness also are overrepresented in people with OUD. Lack of stable housing leads to lower levels of adherence to treatment and higher risk of overdose.

"Housing first" models combined with addiction services demonstrate potential in improving outcomes supporting an argument that social policy is part of effective opioid response (Dasgupta et al., 2018). Taken together, the literature builds to make the argument that the opioid crisis and the opioid epidemic are not biomedical phenomena but broad social and economic disruptions. Effective response frameworks must therefore go beyond delivering healthcare, and also include the delivery of social services, housing support, employment support and reducing stigma.

Government and Policy Responses to the Opioid Crisis

Government and policy responses to the opioid crisis have changed substantially over the last 20 years - shifting from a heavy reliance on supply control and enforcement from more balanced (including prevention, treatment, harm reduction, and surveillance) approaches. The literature underscores the fact that initial policy approaches were often not in line with this emerging epidemiological evidence, however, more recent approaches have been more sensitive to public health principles and evidence-based models of addiction treatment. One of the very first policy tools introduced was the formation of Prescription Drug Monitoring Programs (PDMPs). PDMPs are state or regionally based electronic databases of controlled substance prescriptions that can be used to track a patient's prescription history and can be used by prescribers and pharmacists to check prescription histories. Studies show that effective PDMP implementation is linked with decreases in high-risk prescribing and "doctor shopping", however, results will vary depending on program design and mandatory-use requirements (Patrick, Fry, Jones, and Buntin, 2016). Research shows that PDMPs work best when incorporated into clinical workflow and incorporated with prescriber education as opposed to using them as an isolated surveillance tool.

Another key policy lever is clinical prescribing guidelines. The CDC issued prescribing guidelines for opioids in the treatment of chronic pain in 2016, recommending starting doses to be lower, risks should be carefully reviewed, and non-opioid therapies are preferred whenever possible (Dowell, Haegerich, & Chou, 2016). Evaluations propose the dissemination of guidelines was responsible for the reductions in overall opioid prescribing in subsequent years. However, the literature is also full of unintended consequences such as abrupt tapering and destabilization of patients due to guidelines applied too rigidly rather than clinical individualization (Volkow et al., 2019). This has resulted in calls for balanced implementation that balances safety for patients and treatment needs for pain. Regulatory and legal actions against practices of the pharmaceutical industry have also been prominent. Multiple governments and jurisdictions have filed litigations against opioid manufacturers and distributors for deceptive marketing and a lack of monitoring of suspicious orders. Scholarly analyses highlight the necessity of accountability and deterrent purposes in these legal actions, although their long-term effects are, of course, determined by the manner in which settlement funds are spent-especially whether they are spent on treatment and prevention services (Kolodny et al., 2015).

Expansion of access of medication for opioid use disorder (MOUD), such as methadone, buprenorphine and naltrexone, has been a key policy priority in several countries. There is consistent evidence to show that using MOUD reduces mortality, illicit opioid use and engagement in criminal justice process (Sordo et al., 2017). Policy barriers, however, have impeded access when it comes to access historically. These barriers include waiver requirements on prescribers, limitations to clinic licensing, patient caps, and limitations on reimbursement. Policy changes that decrease treatment restrictions such as prescribing

guidelines and increase insurance coverage are linked with more treatment uptake (Volkow & McLellan, 2016).

Naloxone access laws are another popular area of study for such policy interventions. Naloxone is an opioid antagonist, which provides an antidote to opioid overdose if given in time. Many jurisdictions have either passed standing orders, pharmacy access laws or have Good Samaritan protections to provide more naloxone access to laypersons and first responders. Systematic reviews show that community naloxone distribution is related to lower mortality from overdose (McDonald & Strang 2016). The literature strongly supports naloxone as a high impact low risk intervention when it is combined with training and linkage to care efforts. Harm reduction policy is noted to be more politically challenged but increasingly evidence-based. Policies that allow syringe service programs and supervised consumption sites (where legally allowed) and drug checking services are ways to mitigate transmission of infectious diseases and the issue of fatal overdoses without needing to abstain from a substance. Other reviews conclude that syringe programs reduce HIV and hepatitis C transmission without increasing drug use, and that supervised consumption sites reduce overdose deaths and indicators of public disorder in surrounding areas (Potier, Laprévote, Dubois-Arber, Cottencin, & Rolland, 2014). Policy resistance is often more a function of moral and political issues than of empirical evidence.

Criminal justice policy is also changing. Traditional punitive approaches toward drug possession are under growing scrutiny as it has been found to raise the risk of overdose once released from prison, as well as to disorganize treatment continuity (Binswanger et al., 2013). Diversion programs, treatment courts and de-criminalization models, as alternatives, are being tested. There is some early evidence to suggest that treatments oriented approaches provide improved health outcomes and have the potential to decrease recidivism as opposed to incarceration-oriented approaches. The policy literature has abounded with the idea that isolated interventions are limited in their effect. Multi-component strategies - a mix of prescribing reform, treatment expansion, harm reduction, surveillance and social support are more powerful and result in a more sustainable impact (Dasgupta, Beletsky, & Ciccarone, 2018).

Community and Public Health Intervention Strategies

Community public health, community-intervened opioid crisis response, and public health responses form the operational core of opioid crisis response. While this framework is given form by national policy, when it comes to implementing and having impact, it happens mostly at a community level through healthcare systems, local governments, non-governmental organizations, and peer led networks. The literature emphasizes that the approaches for combatting opioids locally and engaging the community are more effective than a uniform approach of top-down programs because risk patterns for opioid abuse and gaps in service provision vary from region to region. Medication-assisted treatment (also called medication for opioid use disorder, MOUD) is consistently found to be the most effective clinical intervention of treatment for OUD. Methadone and buprenorphine are opioid agonist therapies that stabilize neurobiology, withdrawal, and craving and decrease the risk of mortality. Naltrexone is an antagonist which blocks the effect of opioids but requires full detoxification prior to taking it. Large meta-analyses show that agonist therapies are associated with a significant reduction of all-cause and overdose mortality compared with no medication treatment (Sordo et al., 2017). Community-level expansion of MOUD through primary care integration and development of low threshold clinics are strongly recommended in the literature.

Integrated care models help to improve outcomes by providing addiction treatment in conjunction with mental health and primary care treatment. Because psychiatric comorbidities increase among individuals with OUD, co-located or coordinated services decrease the fragmentation and retention (Volkow et al., 2019). Collaborative care and hub-and-spoke models, in which specialty centers assist the community prescribers, have demonstrated promising results in increasing the reach of treatment. Peer recovery and mutual aid programs are also very well documented. Peer recovery coaches - individuals with lived experience of addiction and recovery - provide navigation, support and engagement services; Studies show that peer involvement assessments enhance treatment linkage rates as well as retention, especially in marginalized populations (Eddie, Hoffman, Vilsaint, Abry, & Bergman, 2019). Mutual aid groups such as Narcotics Anonymous are still widely used, but the evidence is of various qualities; they are generally viewed as beneficial as supplementary supports.

Community overdose prevention efforts are often multi-faceted, reducing the public's risks of overdosing through the distribution, education, and community outreach to communities. Programs that train individuals who use drugs, their families, and their service providers to recognize and respond to overdose have high rates of successful reversal (McDonald & Strang, 2016). Mobile outreach and street based harm reduction teams provide outreach to populations who are not engaged in formal treatment. Prevention programs are focusing on upstream risk factors increasingly. School based and youth focused prevention interventions focus on life skills, coping strategies and substance use education. Evidence shows that interactive and skills-based programmes have been found to be more effective than information-only programmes (UN Office on Drugs and Crime, 2018). Community coalitions coordinating a prevention messages, a safe medication disposal and prescriber engagement demonstrate moderate success in decreasing initiation risk.

Alternative pain management strategies are also another prevention pillar. Multimodal pain management (physical therapy, cognitive behavioral therapy, mindfulness-based intervention, and non-opioid pharmacotherapy) can help to decrease the use of opioids in chronic pain management (Dowell et al., 2016). The expansion of insurance coverage and training for providers in advice on these modalities are quite commonly recommended in the literature. The need to address the social determinants is becoming increasingly recognized. Housing support, employment services, as well as social reintegration programs help increase recovery stability. Recovery housing and supportive employment models are linked to positive outcomes in treatment retention and a lower rate of relapse (Dasgupta et al., 2018). These interventions can be seen as a move away from medical-only systems of care toward recovery-oriented systems of care. Across studies, the success factor of community engagement emerges as cross-cutting. Programs are in consultation with those affected by the disease and are more likely to be adopted and relevant in the cultural context. Public health researchers stress that trust-building, stigma reduction and working with communities are not additional improvements but basic requirements of the implementation effort.

Conclusion

The opioid crisis is a complex and evolving public health emergency that is influenced by the actions of interacting medical, social, economic and policy forces. Evidence reviewed throughout this article has demonstrated that the crisis did not arise from a single source, but was the result of the convergence of increased use of opioids as drugs of choice, commercial motives, regulatory shortfalls, socioeconomic distress, and a lack of integration of addiction

science into mainstream practices of healthcare treatment. Over the years, the epidemic has moved through several phases, from prescription opioids to heroin to highly potent synthetic opioids, consecutively introducing new patterns of risk and issues of intervention. This layered progression underscores the fact that reactive, single focus approaches lack efficacy in the face of adaptive markets of drug examples and shifting user behavior. The health burden is really far beyond overdose mortality. Opioid misuse is associated with chronic medical complications, psychiatric co-morbidity, infectious disease transmission, maternal & neonatal risk, as well as sustained pressure on the emergency and primary care systems. At the same time, the crisis causes pervasive social and economic disruption across areas of family, workforce, housing stability and criminal justice systems. Stigma and social exclusion increase further the level of harm by delaying application of treatment and the policy of punishment instead of care. The evidence base is stacking up very consistently supporting reframing opioid use disorder as a chronic and treatable health condition as opposed to it being considered a moral failing or it being considered a criminal issue.

Research on response strategies shows most efforts to respond have been comprehensive and multi-level. High impact elements include safer prescribing frameworks, prescription monitoring in real-time, more accessible medication treatment, overdose reversal distribution, actual conveyance mental health and addiction services, as well as community driven harm reduction programs. Policy reforms to reduce barriers to treatment, increase naloxone accessibility and help eliminate an adversary of treatment-namely withholding treatment due to incarceration-have demonstrated to be beneficial. Community engagement, peer support, and social determinants of health are key to promoting the durability and reach of an intervention. No single intervention is sufficient and systems of prevention, treatment, harm reduction and recovery support are required to be coordinated.

Going forward, a continued trajectory of improvement is required through the optimization of the clinical practice, public health system and social policy with the established evidence. This includes investing in addiction workforce capacity, incorporating substance use treatment into general healthcare, strengthening surveillance as well as tackling watersheds or upstream factors such as economic instability and untreated mental illness. A long-lasting response to the opioid crisis will need to be adaptive, evidence-based and equity-oriented, knowing how vulnerability and access to care do not find parity. It will only be by integrated and sustained action that the trajectory of the opioid-related harm will reverse in the long-term.

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