The opioid epidemic: How did we get it so wrong?

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American Association of Occupational Health Nurses (AAOHN)
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disclosures

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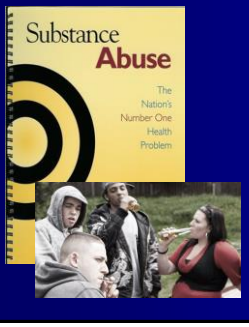
learning outcomes

1. Review national statistics related to opioid use, overdoses, and deaths
2. Explore factors that have contributed to the current opioid epidemic
3. Describe a community-based model to address this problem
4. Consider new Center for Disease Control and Prevention (CDC) guideline for prescribing opioids
5. Engage in questions, answers, and discussion

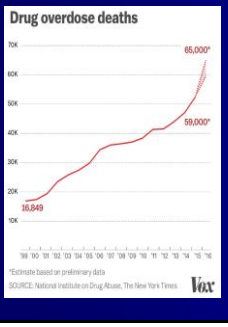
context: the nation's number one health problem



- 2001: "Substance abuse…the problematic use of alcohol, tobacco, and illicit substances…[was named as] the nation's number one health problem." [1]
- 2009: Based on data from 2005, the National Center on Addiction and Substance Abuse (CASA) reported total annual costs of substance use at nearly half a *trillion* dollars. [2]
- 2011: CASA named "Adolescent Substance Use: America's #1 Public Health Problem." [3]
- 2011: Office of National Drug Control Policy (ONDCP) cites non-medical use of prescription medications "the nation's fastest-growing drug problem." [4]

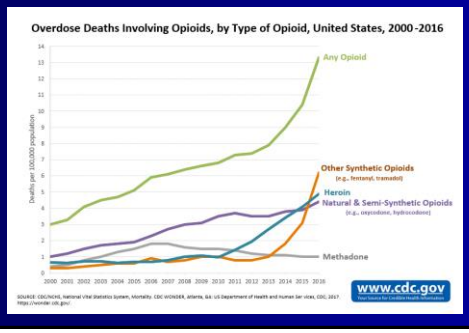
a painful question…

opioid overdose deaths

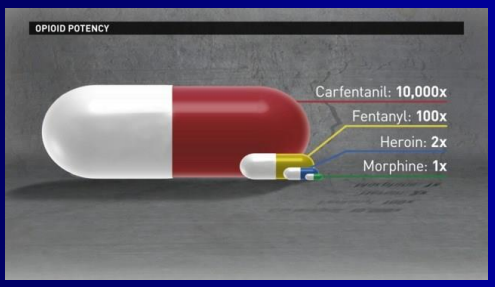


- A function of Rx opioid sales: Enough prescriptions written in the US for every adult to have received a bottle of opioid pain medications
- Opioid overdose deaths quadrupled from 1999 to 2014
- Now the leading cause of accidental deaths, including motor vehicle fatalities
- **A very recent estimate for 2016 is 65,000 opioid overdose deaths**
  - **178 deaths per day**
  - **7 deaths per hour**
- Increased numbers, percentages involve fentanyl, now carfentanil

opioid overdose deaths (CDC, 2017)



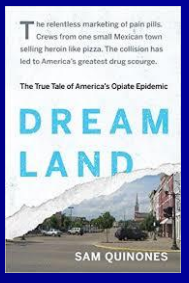
carfentanil



Dreamland (Quinones, 2015) [5]

Contributing factors

- Lack of adequate training to health care providers: pain, addictions
- Marketing
  - Pharma to physicians: promotion of opioid medications as safe, non-addictive if used for pain
  - Unscrupulous "pill mills"
  - "Black tar" heroin
  - Conversion from opioid medications (licit or illicit) to use of heroin
- Pain as the 5th vital sign
  - Patient satisfaction surveys
  - Lack of support for research for non-opioid pain relief
  - Refusals by insurance companies to approve or pay for other forms of treatment
  - Sociocultural factors



acute versus chronic pain

- Opioids can be highly effective in the treatment of acute pain, e.g., post-surgical
- However, there is little or no evidence that opioids are effective in the treatment of chronic pain
- In fact, the use of opioids can actually worsen pain through a phenomenon known as hyperalgesia

a lack of evidence

Most of the misleading claims made by drug companies regarding the safety of opioids in the treatment of pain were based on

- one letter to the editor from Porter and Jick (1980), and published in the *New England Journal of Medicine*
- a retrospective chart review of medically supervised, hospitalized patients
- "...heavily and uncritically cited..."

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients[1] who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,[2] Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

JANE PORTER
HERSHEL JICK, M.D.
Boston Collaborative Drug Surveillance Program
Waltham, MA 02154 Boston University Medical Center

1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind V, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.

a lack of evidence

- This situation was made worse by unethical promotional practices
- "Arthur Sackler revolutionizes drug advertising... making Valium the industries first $100 million drug."

other treatment modalities are effective

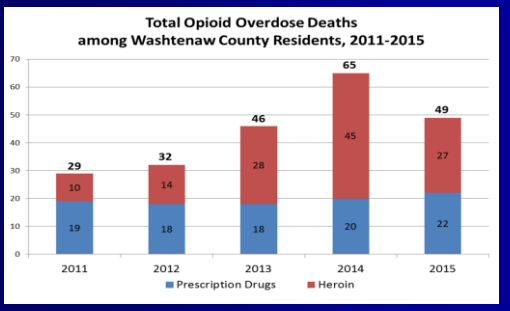
- These may include, but are not limited to
  - alternative, non-addictive medications
  - mindfulness
  - yoga
  - healing touch
- But, these approaches
  - take time
  - require a commitment and participation on the part of the patient
  - do not promise complete elimination of pain

a community gathers: August, 2015

Project Lazarus Model

www.projectlazarus.org

Washtenaw Health Initiative (WHI) Opioid Project



WASHTENAW HEALTH INITIATIVE
OPIOID PROJECT

www.whiopioidproject.org

Dawn Farm Education Series
https://vimeo.com/193126976

Letter from Vivek Murthy, MD, MBA 19th U.S. Surgeon General

"I am asking for your help to solve an urgent health care crisis facing America: the opioid epidemic…we arrived at this place on a path paved with good intentions. Nearly two decades ago, we were encouraged to be more aggressive about treating pain, often without enough training and support to do so safely. This coincided with heavy marketing of opioids to doctors. Many of us were even taught—incorrectly—that opioids are not addictive when prescribed for legitimate pain…The results have been devastating…"

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

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3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.
4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended release/long-acting (ER/LA) opioids.

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

5. When opioids are started…prescribe the lowest effective dosage…carefully reassess benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day…and avoid increasing dosage to ≥ 90 MME/day…

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6. Long-term opioid use often begins with treatment of acute pain…prescribe lowest effective dose of immediate-release opioids…prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

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7. …evaluate benefits and harms…within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation…evaluate benefits or harms…every 3 months or more frequently…If benefits do not outweigh harms…optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

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8. …incorporate strategies to mitigate risk…offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

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11. …avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. …offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

clinical reminders, a summary

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient
- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed
- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid current benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

Comprehensive Addiction and Recovery Act (CARA) 2016

IntNSA Position Paper: The Prescribing of Buprenorphine by Advanced Practice Addictions Nurses

- Strobbe, S., & Hobbins, D. (2012). The prescribing of buprenorphine by advanced practice addictions nurses. *Journal of Addictions Nursing, 23* (2), 82-83.
- "In order to increase safe access to buprenorphine treatment for patients with opioid dependence, it is the position of the International Nurses Society on Addictions (IntNSA) that the Drug Addiction Treatment Act of 2000 (DATA 2000) to be amended to allow for the prescribing of buprenorphine by qualified advanced practice nurses who have both prescriptive authority and specialty certification in addictions nursing."


The Prescribing of Buprenorphine by Advanced Practice Addictions Nurses

ASPMN Position Statement: Pain Management in Patients with Substance Use Disorder


Position Statement

American Society for Pain Management Nursing Position Statement

Pain Management in Patients With Substance Use Disorders

- Oliver, J., Coggins, C., Compton, P., Hagan, S., Matteliano, D., Stanton, M., St. Marie, B., Strobbe, S., & Turner, H.N. (2012). [Dual publication]. Pain management in patients with substance use disorders. *Pain Management Nursing Journal, 13* (3), 169-183. *Journal of Addictions Nursing, 23* (3), 210-222.
- "It is the position of ASPMN and IntNSA that every patient with pain, including those with substance use disorders, has the right to be treated with dignity, respect, and high-quality pain assessment and management."

ENA/IntNSA Joint Position statement

Substance Use Among Nurses and Nursing Students

- Strobbe, S., & Crowley, M. (2017). Joint position statement: Substance use among nurses and nursing students. *Journal of Emergency Nursing, 23*(3), 159-263 [May 2017].
- Strobbe, S., & Crowley, M. (2017). Substance use among nurses and nursing students: A joint position statement of the Emergency Nurses Association and the International Nurses Society on Addictions. *Journal of Addictions Nursing, 28*(2), *104-106* [April/June 2017].

Statement 1

Health care facilities provide education to nurses and other employees regarding alcohol and other drug use, and establish policies, procedures, and practices to promote safe, supportive, drug-free workplaces.

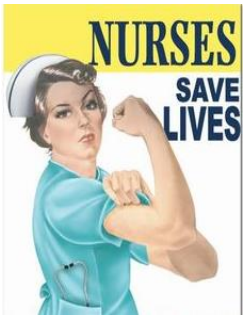
Statement 2

Health care facilities and schools of nursing adopt alternative-to-discipline (ATD) approaches to treating nurses and nursing students with substance use disorders, with stated goals of retention, rehabilitation, and re-entry into safe, professional practice.

Statement 3

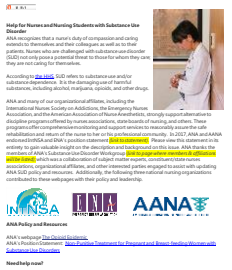
Drug diversion, in the context of personal use, is viewed primarily as a symptom of a serious and treatable disease, and not exclusively as a crime.

Statement 4



Nurses and nursing students are aware of the risks associated with substance use, impaired practice, and drug diversion, and have the responsibility and means to report suspected or actual concerns.

More on Substance Use Among Nurses and Nursing Students



Substance Use Disorders Among Nurses and Nursing Students

Help for Nurses and Nursing Students with Substance Use Disorder

ANA recognizes that a nurse's duty of compassion and caring extends to themselves and their colleagues as well as to their patients. Nurses who are challenged with substance-use disorder (SUD) not only poses a potential threat to those for whom they care, they are not caring for themselves.

According to the ANA, SUD refers to substance use and/or substance use disorder, i.e., to the damaging use of harmful substances, including alcohol, marijuana, opioids, and other drugs.

ANA and many of our organizational affiliates, including the International Nurses Society on Addictions, the Emergency Nurses Association, and the American Association of Nurse Anesthetists, strongly support alternative to discipline programs offered by nurses associations, state boards of nursing, and others. These programs offer comprehensive monitoring and support services to reasonably assure the safe rehabilitation and return of the nurse to her or his professional community. In 2017, ANA and AANA endorsed IntNSA and ENA's position statement, ENA to statement. Please view this statement in its entirety to gain valuable insight on the description and background on this issue. ANA thanks the Emergency Nurses Association, International Nurses Society on Addictions, and American Association of Nurse Anesthetists which was a collaboration of subject matter experts, constituent state nurses associations, organizational affiliates, and other interested parties engaged to assist with updating ANA SUD policy and resources. Additionally, the following three national nursing organizations contributed to these webpages with their policy and leadership.

ANA Policy and Resources

ANA's webpage The Opioid Epidemic
ANA's Position Statement: Non-Punitive Treatment for Pregnant and Breast-feeding Women with Substance Use Disorders

Need help now?

- Position statement now endorsed by
  - American Nurses Association (ANA)
  - American Association of Nurse Anesthetists (AANA)
  - American periOperative Registered Nurses (AORN)
- Disseminated by the National Council of State Boards of Nursing (NCSBN)
- ANA convened Substance Use in Nursing Work Group
- Created landing page on ANA website: "Help for Nurses with Substance Use Disorder," with links to information and resources
- IntNSA President (Strobbe)
  - invited to serve on AANA Peer Assistance Advisory Committee (PAAC)
  - invited to present webinar on opioid epidemic to AAOHN, January 2018
  - invited to address Global Summit for AORN, March 2018

a focus on the opioid epidemic

- 40th Annual Educational Conference, International Nurses Society on Addictions (IntNSA), Las Vegas, Nevada, 2016
- *"Addressing the Opioid Epidemic: Prevention, Intervention, Treatment, and Recovery"*

IntNSA 42st Annual Educational Conference 2018

Substance Use and Recovery-Oriented Care: 21st Century Challenges and Opportunities

- Denver, Colorado
- October 3-6, 2018
- Embassy Suites
- *www.intnsa.org/conference*

what can we do?

- Clean out our own medicine cabinets, discarding expired and unused medications
- Examine our own attitudes regarding substance use and addiction, and those who are affected by it
- Recognize substance use disorder as a treatable disease
- Employ non-opioid pain relief strategies
- Help shape responsible prescribing practices
- Learn about naloxone: what it is, when to prescribe it, and how to administer it ourselves in the event of an overdose
- Be alert to occupational risks for substance use among nurses and nursing students, and advocate for prevention, early intervention, retention, treatment, and recovery

questions, answers, discussion

selected references

1. Horgan, C., Skwara, K.C., Strickler, G. (2001). Substance abuse: The nation's number one health problem. Princeton, NJ: Robert Wood Johnson Foundation.
2. National Center on Addictions and Substance Abuse (CASA). (2009). Shoveling it up II: The impact of substance abuse on federal, state and local budgets. New York: CASA.
3. National Center on Addiction and Substance Abuse at Columbia University (CASA). (2011). Adolescent substance use: America's #1 public health problem. New York: CASA.
4. Office of National Drug Control Policy (ONDCP), US Executive Office of the President of the United States. (2011). Epidemic: responding to America's prescription drug abuse crisis. Rockville (MD): ONDCP.
5. Quinones, S. (2015). Dreamland: The true tale of America's opiate epidemic. New York, NY: Bloomsbury Press.