A Patient-Centered Approach to the Opioid Overdose Crisis

JENNIFER P. SCHNEIDER, MD, PHD

*[**Editor's Note:** Jennifer Schneider, MD, PhD, who specializes in Internal Medicine, Addiction Medicine, and Pain Management, is an internationally recognized expert in two addiction-related fields: addictive sexual disorders and the management of chronic pain with opioids. She has extensive clinical experience in treating patients with chronic non-cancer pain of all types and is recognized as a national expert in the appropriate use of opioids for chronic pain. She is the author of 15 books and numerous articles in professional journals, including the landmark book, "The Wounded Healer," which she co-authored with Richard Irons. She is a brilliant and compassionate professional committed to educating others in her fields of specialty. She resides in Tucson, AZ and can be reached at jennifer@jenniferschneider.com. This essay (special to the JMSMA) provides an informed and insightful patient-centered approach to the current opioid overdose crisis.] — **Ed.***

The assumption that decreasing doctors' ability to prescribe opioids is the most effective (and only) solution to the "opioid crisis" is a mistaken approach. One problem is that statistics on opioid deaths combine several groups of people: (1) Usually – compliant patients who accidentally took too many prescribed pills and overdosed. (2) People trying to commit suicide. (3) People who purchased prescription drugs on the street, either to treat their anxiety, depression, etc. or to feed their addiction with a high. (4) People who purchased illegal drugs on the street, such as heroin and fentanyl. (5) Young people (and older ones as well) whose source was a bottle of opioids in a relative or friend's home. The type of user who is the main source of the increasing "opioid deaths" is #4, and their numbers are increasing. But this isn't obvious if all that people hear about is the total number of deaths.

The real solution to opioid-related overdose deaths requires getting to the basics. The essential problem is poisoning due to overdosing on legitimately prescribed or illegally obtained opioids. Why do people take opioids in the first place? Some do because of pain, and they may accidentally take too much. Others are treating emotional problems such as anxiety, depression, and PTSD (post-traumatic stress disorder) related to childhood or adult trauma.[1] Some of these persons are seeking to feel normal (opioids can be effective antidepressants or anxiolytics.[2] In many cases members of this group were initially prescribed opioids for pain, but when they found that it was very effective for their psychological problems, they became committed to continuing to take the opioids. Then there are addicts seeking euphoria. Finally, still others are teens who began by experimenting with opioids.

Why do people prefer to buy prescription drugs (rather than illegal drugs) on the street? One common reason is that with prescription drugs, they know exactly what dose they're getting. This knowledge makes them safer than heroin/fentanyl/etc., which are not regulated. With the illegal drugs you don't know what dose (or even what drug) you're actually getting, and the risk of accidental overdose deaths is much greater than with the prescription drugs. After 2010, when the first extended-release oxycodone (OxyContin) was made into an abuse-deterrent formulation, the street value of OxyContin dropped dramatically (because it could no longer be crushed and inhaled or injected, and what gives a person a high is not the concentration of the drug in the blood stream but rather how quickly it gets into the brain.[3] Instead, people switched to heroin,[4] resulting in a massive increase in overdose deaths due to heroin; from 2010 to 2014, the age-adjusted rate of drug overdose deaths involving heroin more than tripled;[5] and now the availability of fentanyl (and its similar versions) is worsening the situation. Because nearly every extended-release opioid is now in an abuse-deterrent formulation, their use too is decreasing and there is more of substitution of heroin and illegally obtained fentanyl. So, when we look at it, the cause of the increase in overdose deaths "due to opioids" was the decreased availability of prescription opioids on the street. This already shows us that decreasing the availability of prescription drugs on the street did not decrease the number of opioid deaths, but rather increased it!!!

As Joshua Sharfstein, former Principal Deputy Commissioner of the FDA wrote in February 2018, "At a time when most insurers still do not provide adequate reimbursement for nonpharmaceutical approaches to pain or treatment for opioid use disorder, overly restrictive prescribing policies risk pushing patients with pain or addiction to illicit drugs, a transition many have made. A few distraught patients have even committed suicide."[6] The more frequently new rules appear and result in fewer opioid prescriptions, the more people will be using unregulated drugs such as heroin and illegally produced fentanyl, with their increased risk of accidental overdose deaths. You may have already heard, as we have in my state, Arizona, how HAPPY the producers and sellers in Latin America and other places are with the currently increasing regulations in the U. S. regarding opioid prescribing. What they see is an INCREASED market for their heroin & fentanyl!!!! Their business is booming!

A patient-centered approach for opioid prescribing requires learning about the patient's life, including a thorough risk assessment. What is a day in the patient's life like? Are they employed? Do they have a support system of friends and family? How active physically are they? Personal or family history of drug or alcohol abuse or addiction? There are several simple tools available for risk assessment, such as the Opioid Risk Tool[7]

or SOAPP. Obtaining old records is important, as is consulting the state's Prescription Drug Monitoring Website. Obtaining a urine drug screen will provide information about what relevant drugs the patient has recently taken. Childhood trauma is another risk factor for abuse or misuse;[8] it can be assessed with the 1-page Adverse Childhood Experiences (ACE) questionnaire.[9] Patients with vulnerabilities should not be denied pain treatment, but must be followed carefully.

Patients whose function and quality of life is improved by opioids need to continue getting them (usually not in isolation, but along with other modalities); many of them are able to continue taking the same dose for years.[10] Those patients who are "treating" their psychological problems with opioids, and those at risk of addiction, definitely need to have other modalities, including behavioral health assessment and treatment [including addiction treatment if that is an issue], and including the necessity for them to become engaged in their chronic pain treatment: This means they are willing to go to physical therapy and do home exercises; go to an interventional pain specialist if warranted; see a behavioral health specialist if they are resistant to becoming engaged in their treatment and/or have unresolved childhood [or other] trauma issues; quit smoking if they smoke; work on losing weight if they're obese; lower thier blood sugar if they're diabetic, etc. Pills should not be the only treatment. Physicians, patients, and government officials need more understanding of the nature of addiction and the role of behavior health disorders. There is also a need for public education efforts to dispose of unused opioids, which are the main source of opioid overdose deaths of high-school age teens.

The real solution must make these modalities accessible to pain patients, who often can't afford them, or their insurance won't pay. That's the big problem. Patients need to be able realistically to benefit from a "team effort." Recently what was probably the best pain clinic in my city closed. Why? The deciding factor was that the insurance companies wouldn't pay for treatment by the pain psychologist who worked there full time and focused on treatment of the root psychological causes of opioid overuse and high-risk use. Unfortunately, insurance companies often prefer to pay only for pills and procedures. They may be willing to pay for naloxone, a medication which will prevent an imminent opioid overdose death, but naloxone can't change someone's lifestyle and stop them from further overdoses. What is also needed is addiction treatment, and insurance companies often will not pay for inpatient or outpatient treatment.

The widespread belief (as recently stated by an "expert" consultant to the Arizona legislature) that "80% of patients on chronic opioids are addicted" needs to be corrected with an understanding of the difference between addiction and physical dependence.[11] There is no quality evidence to support the 80%; on the contrary, the evidence suggests that a only a small minority of pain patients on chronic opioids develop an Opioid Use Disorder (the current name for addiction).[12,13] Nora Volkow of the NIH has written, "Addiction occurs in only a small percentage of persons who are exposed to opioids – even among those with preexisting vulnerabilities."[14] Instead, what we have now is a widespread (erroneous) belief that doctors are turning most of their chronic pain patients into addicts, who are then at a high risk of overdose deaths. If you believe that, then no wonder you believe that the solution is to stop prescribing opioids. If you understand what addiction is and the role of psychological issues in many patients, you're in a better position to determine if a patient with chronic pain is also addicted or has a psychological disorder and should not be treated with opioids unless an appropriate specialist is also on the team, there are appropriate safeguards in place, etc. And of course, patients who are diverting their prescribed opioids should definitely not be treated with opioids.

Yes, correcting the misconceptions of prescribers and the public about the nature of addiction versus physical dependence, the actual (relatively small) likelihood of de novo addiction among chronic pain patients, the diverse causes of opioid overdoses, etc. is an important first step. But the ultimate solution to the opioid crisis is to shift the focus from a drastic reduction in opioid prescribing (an approach which penalizes a large number of chronic pain patients whose pain level and functioning have benefited from treatment with opioids) to a patient-centered approach[15] that involves additional information gathering, a team approach, and consideration of a broader set of medication and non-medication treatment modalities including behavioral health. ■

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