Policy Issue: Seek a balanced response to the opioid crisis

Opioid related overdose deaths have indeed increased in recent years both across the nation and here in Texas. The trend across the nation is to react swiftly with new regulations and restrictions on the use of and prescribing of opioid medications. These efforts may be aimed at physicians, pharmacists, and even patients.

However, measuring deaths from overdose does not tell the complete story behind the unfortunate misuse and abuse of opioids. Furthermore, it does not speak to the thousands of patients who experience improvements in quality of life with proper use of these medications.

Recommendation

An effective state policy to address the multidimensional opioid crisis should involve thoughtful strategies that:

1) Define the opioid epidemic as part of a larger context of substance abuse and addiction disorders;
2) Continue and increase support for programs in both outpatient and inpatient settings that seek to prevent and manage addiction;
3) Promote education for the public as well as health care professionals regarding non-opioid and non-pharmacologic methodologies for coping with chronic pain; and
4) Offer a balanced, evidence based, and interdisciplinary approach to the regulation of opioid based medications, particularly acknowledging the needs of patients requiring palliative care, hospice care, and oncological care.

The goal of the Council's recommendation is to encourage deeper exploration regarding opioid abuse, highlight educational opportunities, and facilitate a truly meaningful response to this growing epidemic.

Recommendation

Misuse of opioid medications is indicative of the broader issues of substance abuse and addiction disorders. Whether a person is taking their neighbor's pain pills, binge drinking or snorting cocaine, the reason for initial use is

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often far more telling than the particular mechanism. Often individuals lack positive coping mechanisms to combat either the everyday stresses of life or extreme circumstances such as physical, sexual, or emotional abuse as well as trauma. Without alternatives, a person may turn to negative coping mechanisms, which include substance misuse and abuse. Indeed, there are many links between poor coping skills and increased likelihood of addiction. While treatment and recovery programs are vital to decreasing dependence on chemical coping, the Council recommends continued efforts toward preventing substance abuse through public education and funding for counseling services. These should be available in the community setting as well as in the acute setting (i.e. hospital).

Pain is real. It effects everyone at some point in their lives—often serving as a warning of some greater problem. Unfortunately for some people, the pain continues beyond the initial injury and perhaps even long after the injury has healed. It has been estimated that at least 100 million Americans are affected by chronic pain at the cost of roughly $600 billion dollars a year in combined healthcare expenses and lost productivity.[1] Yet, while Americans consume more opioid based medications as compared to any other country, the word "pain" continues to be present in five of the top ten chief complaints in the ED. Clearly, opioids have been unable to completely address patients' pain despite decades of increasing efforts.

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In the middle of the 20th century, Dame Cicely Saunders introduced the concept of total pain. This model broadened the definition of pain to include not just the physical but the emotional, spiritual, and social elements of a person's being. The level of suffering experienced in each aspect of a person's life contributes to the overall level of pain that person is living with. In addition, increased distress in one category can manifest itself in another. For years, researchers have established correlations between emotional and physical ailments. Countless studies link depression with physical pain. This includes patients that may have presented with a physical complaint but actually suffered from depression and those patients with chronic pain who

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[1] Gaskin, Darrell J, and Patrick Richard . 2011. *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research.* Washington DC: National Academies Press.

subsequently developed depressive symptoms.[2] There is a significant association between sexual abuse and chronic pelvic pain.[3] Similarly, social factors affect a patient's pain. Compared to the most affluent in society, moderate and low income populations are one and a half time more likely to have chronic pain.[4] Pain and suffering are more complex than would appear on the surface.

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While this notion has influenced recent clinical guidelines for the management of chronic pain, palliative care (including SPC and HPC) has long recognized the validity of total pain and has always incorporated this concept into the practice of helping patients and families navigate the effects of serious illness. The principle of matching a treatment to the root cause of suffering is a sacred tenet of palliative care. It allows for better validation of a patient's suffering while preventing the tunnel vision that can occur in developing treatment regimens. Opioids have their role in the treatment of physical pain but so do non-opioid based treatments such as NSAIDs, neuroleptics, or even personally tailored transdermal medications. Furthermore, attempting to treat emotional or spiritual suffering with opioids is likely to be as successful as treating diabetes with opioids. Health care providers know this; however, until recently the medical community, pharmaceutical companies, and the general public have had both a limited definition of pain (ex. Pain is the 5th vital sign from the 1990s) and limited resources to adequately address the root cause of suffering. As such, opioids have largely become the mainstay for both the treatment of generalized pain and for coping with chronic pain. Broadening the definition of pain allows for broadening the definition of an analgesic. It opens the

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[2] Trivedi, Madhukar H. 2004. "The Link Between Depression and Physical Symptoms." *Primary Care Champion Journal of Clinical Psychiatry* 12-16.

[3] Ennemoser, A, E Sölder, A Lampe, C Schubert , G Rumpold, and W Söllner. 2000. "Chronic pelvic pain and previous sexual abuse." *Obstetrics and Gynecology* 929-933.

[4] Davies , Kelly A, Alan J Silman, Gary J Macfarlane, I Barbara Nicholl, Chris Dickens, Richard Morriss, David Ray , and John McBeth. 2009. "The association between neighbourhood socio-economic status and the onset of chronic widespread pain: Results from the EPIFUND study." *European Journal of Pain* 635-640.

door to countless positive coping mechanisms meant to address all aspects of suffering that contribute to the patient's total pain. These could include counseling, exercise, faith groups, and music therapy. The Council recommends investing in education for the public as well as for health care professionals regarding non-opioid and non-pharmacologic methodologies for coping with and managing chronic pain.

Although it has been discussed that opioids may not completely resolve the larger concept of total pain, it is equally important to remember that opioid based medications remain some of the most effective tools for symptom relief. When utilized correctly, opioids remain an essential part of an effective treatment plan for acute physical pain, chronic malignant pain, and dyspnea. This is especially true in patients suffering from severe or life ending illnesses—that is patients receiving palliative care or hospice services. Current responses to the opioid crisis may unintentionally marginalize this patient population. Limits on manufacturing create supply shortages and new policies complicate dispensing at local pharmacies. In general many prescribers have developed a misplaced fear of a medication that can actually bring tremendous relief from the symptom burden of advanced disease. Already, there are deleterious effects on patients. Recent studies have shown that up to 42% of cancer patients have inadequate pain control and some patients must wait days while battling with unfounded insurance restrictions on opioid coverage. With respect to patient care, under treating is just as egregious as overprescribing. To this effect, the Council cautions law makers against demonizing the medication itself and recommends a balanced approach to the regulation of opioid medications.

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The opioid epidemic is a growing concern across the nation and the state. However, it should be noted that despite a roughly 22% decrease in the number of opioid prescriptions written over the last four years, the number of opioid overdoses has increased by 50%.[5] During this same time frame,

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[5] David, Doolittle. 2018. *Following National Trend, Texas' Opioid Prescriptions Drop* . May 1. Accessed 2018. https://www.texmed.org/TexasMedicineDetail.aspx?id=47453.

opinions[6] have become polarized with opioid medications largely seen (by both public and provider) as either all good or all bad. While the Council agrees with the level of alarm, it is the opinion of the Council that the issue is more complex and multilayered. As such, any mindful approach toward a meaningful solution would serve to be multilayered as well.

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