Townhall

America's Crisis with Opioids: Confronting the Crisis

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Gary Mendell of Shatterproof focuses totally on solving this epidemic. He realizes he cannot have a 100% success rate, but he believes we can reduce this crisis facing our country by half in a few short years with very little additional funding as he outlined to the Presidential Commission headed by Governor Christie.

One means is obviously to cut down the quantity of opioids that are legally supplied. The CDC (Centers for Disease Control and Prevention) has announced that the amount of opioids prescribed peaked in 2010 and has fallen each year through 2015. This is a good start, but the level of prescribed opioids is still three times the amount that were handed out in 1999. Per the CDC, the amount of opioids prescribed in 2015 was still enough for every American to be medicated around the clock for three weeks.

One of the means to control the outflow is through the registration of doctors reporting their prescriptions to a statewide database. Forty-nine states have established a prescription drug monitoring program (PDMP). Missouri Governor Eric Greitens ordered the formation of one in his state -- the last one to form a database.

Dr. Phil Kurzner told me about how this works in California. He said it takes some effort on the part of the physician, particularly in the context of their (typically) very busy work day. In one version, the physician enters the electronic order for a restricted opioid. A text message with a code to enter is then received, much like other code-based systems used to validate the identity of the user. This is to assure that the system is tamper-proof and only the registered subscriber is on the system. Kurzner stated similar efforts are underway not just in California, but throughout the country. He predicted this will become mandatory soon. This also allows tracking of both the prescriber authorizing the opioid and the patients receiving them.

The only medications that need be reported to the database are Level II, III, and IV drugs. These drugs include morphine, methadone and other opioids.

Kurzner, who was never a heavy prescriber of opioids despite being a surgeon, does see advantages to the electronic system. He stated "Physicians can go on the website and check whether the patient has a history of doctor/pharmacy shopping for these drugs. Also, I think it makes the doctor think more carefully before issuing the drugs to make sure they are not overprescribing." Kurzner thinks there is a relatively small number of docs who are guilty of overprescribing. Whatever the physician's motivations, patterns and trends in prescribing can

quickly identify heavy prescribers. The best justification for heavy prescribing of opioids would be surgeons on a short-term basis after invasive, acutely painful surgeries. There is also a clear role for physicians who specialize in acute pain management situations.

A common example is the cancer patient, with spreading of cancer to bones or other body parts causing severe pain. Kurzner stated "There is growing consensus among practicing physicians that the use of opioids in chronic pain management is not optimal. There are better therapies now for these situations, reducing the risk of addiction from often times well intended prescribing of opioids."

Other than reporting their prescriptions to a database, there are some basic common-sense suggestions from the CDC for health care professionals:

Use opioids only when benefits outweigh risks:

· Start with the lowest effective dose of immediate release opioids.

· For acute pain, prescribe only the number of days that the pain is expected to be severe enough to require opioids.

· Reassess benefits and risks if considering dosage increases.

The idea is that a doctor should be seriously thinking about each prescription before signing that pad.

Mendell made a series of recommendations to the Presidential Commission headed by Governor Christie in addition to use of the PDMP system. Let us summarize those recommendations:

1. Shatterproof believes the focus should be on treatment for opioid addiction:

80% of those receiving treatment do not receive medical treatment which is the most potent weapon to reduce overdose deaths. There are three drugs used to do this: Buprenorphine, Methadone and Naltrexone. These drugs suppress symptoms of opioid withdrawal and decrease cravings for opioids. It helps patients stay in treatment with commensurate reduction of illicit opioid usage.

Shatterproof believes that there are two things that should be focused on:

A. More funding to make the drugs available.

B. More and wider availability of buprenorphine through eliminating the eight hours of required training to prescribe the drug.

Shatterproof contends funding for treatment is a serious problem. They recommend the elimination of prior authorization for any opioid treatment by all insurance plans. They also recommend the federal government fill any funding gaps for proper treatment that is not currently funded by private or public insurance.

Shatterproof also contends that, with proper treatment, "substance use disorders can be effectively treated, with recurrence rates no higher than other chronic diseases such as diabetes, asthma and hypertension."

2. More needs to be done to rescue those experiencing an overdose. Naloxone is a medication that can instantly reverse an overdose. It is inexpensive, has virtually no side effects and is easy to use. Naloxone is widely accepted to be effective, but needs to be more readily available.

Shatterproof recommends Naloxone be available without doctor prescriptions and that anyone administering the drug be indemnified for its use in an emergency. Having Naloxone available during opioid overdoses could save thousands of lives.

3. Education of the opioid epidemic for the medical community is sparse. Only seven percent of medical schools require courses in substance-use disorders. It is unknown how many doctors, dentists or nurses who are currently practicing have any education on this issue which has now been declared a national emergency.

Shatterproof recommends education for all medical personnel currently in school. That means all currently licensed medical personnel, particularly with prescribing capability, need more education.

4. 30-40% of inmates released from federal/state/local prison facilities were incarcerated for opioid-related crimes. Shatterproof recommends mandatory treatment to stem the problems these people have and stop them from spreading use and crime throughout the community.

5. The government needs to focus on the legal availability of opioids. The amount prescribed is declining, but not enough. That can be done through education of all parties and identifying the potential abuses in the supply chain. The PDMP program will help to accomplish that.

6. Not only do medical personnel need further education, the public does as well. This can be done through a community-wide campaign. Shatterproof recommends any time a patient receives more than a three-day prescription they sign a consent defining risks and benefits of the opioids they are receiving.

Mendell believes that with the implementation of these recommendations, together with the formation of a Substance Use Disorder Treatment Task Force, we would see a precipitous drop in overdose deaths in a reasonably quick period.

One of the more controversial recommendations that Mendell has made is to limit opioid prescriptions to three days. Mendell told me that doctors are resisting this because they think they will lose control of the doctor-patient relationship.

I spoke to Dr. Jeffrey Singer, a general surgeon and a senior fellow at the CATO Institute. Singer has written many times on this topic. He agrees that doctors are resisting and he believes for good reason. He prefers the decision be left between the doctor and patient instead on black and white laws written by elected officials.

Singer points out that huge numbers of Americans (the vast majority of users) use opioids annually with no problems of misuse or abuse. He stated “These patients have significant benefits from the drugs and why should we as doctors not help those patients.”

He also discussed that there are two kinds of patients that might receive an opioid prescription. These two are referred to as either “episodic” or “chronic.” Those defined as episodic would be someone who has an accident, needs an operation, then moves on with their lives. Chronic is as it sounds -- someone who has ongoing problems like back pain, etc., that cannot be relieved by an

operation and/or other means of relieving that pain cannot be achieved. Singer is particularly concerned those patients will not be properly served.

A study of 136,000 overdose victims treated in emergency rooms in 2010, as stated in a column published in Scientific American, showed just 13% had a chronic pain disorder. The idea is that the other 87% would be other users -- many of them obtaining their opioids illegally. Stopping access to the 'chronic' population would not solve the problem and potentially harm them.

Singer also points to some other facts that may bring into question that focus should be on doctors and prescriptions. As was stated before, the number of prescriptions for opioids has gone down every year since 2010, yet the number of opioid overdose deaths continues to rise. With the reduction of available legal drugs and the focus on limiting peoples' access, Singer believes they are being driven to the illegal market which would account for the rise of heroin-induced overdoses.

Singer strongly believes that since there has never been a drug free society that attempting to focus on that as a solution will not work. He is an adherent of a public health philosophy called Harm Reduction which focuses on reducing the harms that drugs do in this country.

Singer does agree with Mendell; prescribing and evidence-based treatment programs are a major part of the answer. Punishment will not be the answer. Singer expressed we have had the war on drugs for close to 50 years and it has not gotten us very far. President Trump's attempt to shut down the Southern border may halt whatever immigrants might be bringing drugs, but Singer fears the drugs will still find their way through.

We are already spending huge sums to deal with the effects of substance abuse. It is estimated that from public and private sources, some $34 billion was spent in 2014 by Americans on treatment. That seems merely a beginning to confront this problem.

An all-out effort to get our heads around this problem needs to be made. Educating the public on how big and dangerous this problem has become is the first step. Educating our medical community of the challenges they face is broadening. A private-public partnership is needed because we cannot tolerate the devastation that crisscrosses our country and steals the lives of far too many citizens. The time is now before we experience even more grief.