The Opioid Epidemic Part I: How We Got Here

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Disclosures

I have no conflicts to disclose.
Learning objectives

● Recognize how and why opioid prescribing has changed from 1980 to 2016.

● Identify the neurobiological, sociocultural, and psychodynamic factors driving over-prescribing and over-consumption of prescription opioids.

● List ideas for what health care providers can do to target and substantially reduce this public health crisis.
How did we get here?
Pre- 1980’s
Late 1990's
Link between opioid prescribing and opioid deaths
Pill mill doctors?
We’re all prescribing too many opioids

Figure 1. Top 25 Prescriber Specialties by Total Medicare Part D Claims for Schedule II Opioids in 2013

Values are reported on logarithmic scale.

Jonathan H. Chen, MD, PhD1,2; Keith Humphreys, PhD1,2,3; Nigam H. Shah, MBBS, PhD4, Anna Lembke, MD3
Big Pharma co-opts Big Medicine
4 Myths of opioids

• Myth #1: Opioids work for chronic pain
• Myth #2: No dose is too high
• Myth #3: Less than 1% get addicted if Rx’d by a doctor
• Myth #4: Pseudo-addiction
Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain: The SPACE Randomized Clinical Trial

Erin E. Krebs, MD, MPH; Amy Gravely, MA; Sean Nugent, BA; Agnes C. Jensen, MPH; Beth DeRonne, PharmD; Elizabeth S. Goldsmith, MD, MS; Kurt Kroenke, MD; Matthew J. Bair; Siamak Noorbakhshi, PhD

**IMPORTANCE** Limited evidence is available regarding long-term outcomes of opioids compared with nonopioid medications for chronic pain.

**OBJECTIVE** To compare opioid vs nonopioid medications over 12 months on pain-related function, pain intensity, and adverse effects.

**DESIGN, SETTING, AND PARTICIPANTS** Pragmatic, 12-month, randomized trial with masked outcome assessment. Patients were recruited from Veterans Affairs primary care clinics from June 2013 through December 2015; follow-up was completed December 2016. Eligible patients had moderate to severe chronic back pain or hip or knee osteoarthritis pain despite analgesic use. Of 265 patients enrolled, 25 withdrew prior to randomization and 240 were randomized.
Why the SPACE trial is the gold standard

• 12 months in duration

• Studied opioid-naïve patients in a primary care setting, including patients with severe depression and post-traumatic stress disorder

• Participants were regularly assessed for medication misuse, including checking the prescription drug monitoring database and urine drug testing

• Not sponsored by an opioid manufacturer
Key opinion leaders

Continuing medical education
Professional medical societies and patient advocacy organizations

Recent investigative reporting from the Milwaukee Journal Sentinel/MedPage Today and ProPublica revealed extensive ties between companies that manufacture and market opioids and non-profit organizations such as the American Pain Society.

According to the Milwaukee Journal Sentinel/MedPage Today, a “network of national organizations and researchers with makers of narcotic painkillers...”
The Joint Commission

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<td>Blood Pressure</td>
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![Emotion Scale]

No pain Discomforting Distressing Intense Utterly horrible Unimaginable unbearable

Very mild Tolerable Very distressing Very intense Excruciating unbearable

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7th International Conference on Pain and Chemical Dependency, June 2007

Sponsors include:
- Abbott Laboratories
- Alpharma Pharmaceuticals LLC
- Cephalon, Inc.
- Endo Pharmaceuticals
- King Pharmaceuticals
- Purdue Pharma L.P.

Slide materials courtesy of Dr Andrew Kolodny, PROP
The Federation of State Medical Boards

Model Policy for the Use of Controlled Substances for the Treatment of Pain

Distributed by 21 state medical boards to over 150,000 clinicians.

The book’s sponsors include:

- Abbott Laboratories
- Alpharma Pharmaceuticals LLC
- Cephalon, Inc.
- Endo Pharmaceuticals
- King Pharmaceuticals
- Purdue Pharma L.P.
Where are we now?
The second wave of the epidemic

Overdose Deaths Involving Opioids, United States, 2000-2016

We’re still prescribing too many opioids
The U.S. continues to consume a disproportionate amount of the world’s Rx opioids

U.S. outstrips other rich nations in opioid Rx’ing

Americans consume more opioids than any other country

Source: United Nations International Narcotics Control Board
Credit: Sarah Frostenson
CDC data opioid prescriptions/100 persons

- U.S. average in 2012 = 81 opioid Rx’s/100 persons (255 million total)
- U.S. average in 2016 = 66 opioid Rx’s/100 persons (214 million total)
- Highest state average in 2016 = Alabama at 121 opioid Rx’s/100 persons
- Lowest state average in 2016 = District of Columbia at 32 opioid Rx’s/100
- Some counties with rates 7x the national average
- Montrose, CO in 2016 = 80 opioid prescriptions per 100 persons
CDC data opioid prescriptions/100 persons
(2016 state)
CDC data opioid prescriptions/100 persons (2016 county)
Montrose, CO
12 Month-ending Provisional Number of Drug Overdose Deaths

Based on data available for analysis on: 9/5/2018

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: United States
Colorado opioid overdose deaths still going up

Based on data available for analysis on: 9/5/2018

Figure 1a. 12 Month-Ending Provisional Counts of Drug Overdose Deaths: Colorado

Number of Deaths


12 Month-Ending Period
Figure 1b. Percent Change in Reported 12 Month-ending Count of Drug Overdose Deaths, by Jurisdiction: February 2017 to February 2018

Legend for Percent Change in Drug Overdose Deaths Between 12-Month Ending Periods

-31.1

-31.1
Opioid misuse (NSDUH 2016)

11.5 Million People with Past Year Pain Reliever Misuse (97.4% of Opioid Misusers)
641,000 People with Past Year Pain Reliever Misuse and Heroin Use (5.4% of Opioid Misusers)
948,000 People with Past Year Heroin Use (8.0% of Opioid Misusers)
10.9 Million People with Pain Reliever Misuse Only (92.0% of Opioid Misusers)
307,000 People with Heroin Use Only (2.6% of Opioid Misusers)
11.8 Million People Aged 12 or Older with Past Year Opioid Misuse
How Rx opioids obtained (NSDUH 2016)

- Given by, Bought from, or Took from a Friend or Relative: 53.0%
- From Friend or Relative for Free: 40.4%
- Bought from Friend or Relative: 8.9%
- Took from Friend or Relative without Asking: 3.7%
- Some Other Way: 3.4%
- Got through Prescription(s) or Stole from a Health Care Provider: 37.5%
- Bought from Drug Dealer or Other Stranger: 6.0%
- Prescription from One Doctor: 35.4%
- Stole from Doctor's Office, Clinic, Hospital, or Pharmacy: 0.7%
- Prescriptions from More Than One Doctor: 1.4%

11.5 Million People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year
The hidden epidemic – benzodiazepines: 7-fold increase in overdoses between 1999-2015

Lembke, A., Papac, J., Humphreys, K. Our Other Prescription Drug Problem, New England Journal of Medicine, 2018
September 2017

● 28 year old male with chronic pain
  ○ 40 mg Opana BID
  ○ 30 mg Dilaudid qD
  ○ 60 mg Oxycodone qD
  ○ 20 mg Valium qD
  ○ 65 mg Phenobarb qD
  ○ 30 mg Temazepam qD
  ○ 8 mg Xanax qD

● MED = 470
A deeper look
The canary in the coal mine...
Opioids the solution ...?
What motivates the drug-seeking patient?

Neuroadaptation
The Sycophant
The Exhibitionist
The Dynamic Duo
The City Mouse and the Country Mouse
The Loser
The Weekender
The Twin
The Doctor-Shopper
The Bully
What motivates the compassionate doctor?
A pleaser
Responding to a ‘higher calling’
Socialized to empathize and believe patients

Put yourself in their shoes
Socialized to practice ‘evidence based medicine’
“Not everything that counts can be counted …”
-William Bruce Cameron

- Clinical judgment
- Clinical experience
- Intuition
Motivated by mutually affectionate relationships
Martin Buber (1878-1965)

- “Man wishes to be confirmed in his being by man, and wishes to have a presence in the being of the other. ... Secretly and bashfully he watches for a YES which allows him to be and which can come to him only from one human person to another.”
Invisible forces continue to drive overprescribing
#1 The Toyota-ization of medicine
Doctors leaving private practice

The P-Paradigm

- Palliate Pain
- Prescribe Pills
- Perform Procedures
- Protect Privacy
- Please Patients

Lembke, A., Why Doctors Prescribe Opioids to Known Opioid Abusers, NEJM, 2012
Dr. Anna Lembke MD

3.0 ★★★★★ ?/4
2 reviews
Psychiatrist
15 years of experience
Video profile
✔ Accepting new patients

401 Quarry Rd
Palo Alto, CA 94304
Phone number & directions

Patient Reviews

Overall Rating: 3.0 ★★★★★
Total Ratings: 7
Total Reviews: 2

- Ease of Appointment: ★★★★★
- Bedside Manner: ★★★★★
- Promptness: ★★★★★
- Spends Time With Me: ★★★★★
- Courteous Staff: ★★★★★
- Follows Up After Visit: ★★★★★
- Accurate Diagnosis: ★★★★★
- Average Wait: 5 minutes

★☆☆☆☆ | Care that worsens your condition | show details

by Corey on Jun 25th, 2013
Really wish I had seen this site's reviews before making an appointment with this physician. She provides the kind of care that will make you wish you had never sought help in the first place. Wrong diagnosis, wrong medication. In some cases this can be terrible. Seek help from someone else.
The Cost of Satisfaction
A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality

Joshua J. Fenton, MD, MPH; Anthony F. Jerant, MD; Klea D. Bertakis, MD, MPH; Peter Franks, MD

Background: Patient satisfaction is a widely used health care quality metric. However, the relationship between patient satisfaction and health care utilization, expenditures, and outcomes remains ill defined.

Methods: We conducted a prospective cohort study of adult respondents (N = 51,946) to the 2000 through 2007 national Medical Expenditure Panel Survey, including 2 years of panel data for each patient and mortality follow-up data through December 31, 2006, for the 2000 through 2003 subsample (n = 36,428). Year 1 patient satisfaction was assessed using 5 items from the Consumer Assessment of Health Plans Survey. We estimated the adjusted associations between year 1 patient satisfaction and year 2 health care utilization (any emergency department visits and any inpatient admissions), year 2 health care expenditures (total and for prescription drugs), and mortality during a mean follow-up duration of 3.0 years.

Conclusions: In a nationally representative sample, higher patient satisfaction was associated with less emergency department use but with greater inpatient use, higher overall health care and prescription drug expenditures, and increased mortality.
#2 Medicalization of poverty
The poor treated differently (2010)

- People receiving Medicaid are prescribed opioid painkillers
  - at $2\times$ rate of non-Medicaid patients
  - and die from prescription overdoses at $6\times$ the rate.

Medicaid opioid overprescribing continues

*FIGURE 4* Average Number of Incidences of Indicators for Potential Inappropriate Prescriptions of Opioids per Patient by Insurance Type, Age, Gender, Race/Ethnicity, and Year

<table>
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<tr>
<th>Year of Study</th>
<th>Number of Incidences per Patient</th>
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<tr>
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<td>2010</td>
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</tr>
<tr>
<td>2013</td>
<td>2.0</td>
</tr>
<tr>
<td>2014</td>
<td>2.5</td>
</tr>
</tbody>
</table>

**Legend:**
- Age 55-64, 2.71
- Age 45-54, 2.60
- Missing race, 2.20
- FFS, 2.06
- Male, 1.69
- White, 1.68
- Age 35-44, 1.41
- Female, 1.12
- Hispanic, 1.02
- Other, 0.67
- MC, 0.63
- Black, 0.62
- Age 18-34, 0.41

*FFS = fee-for-service, MC = managed care.*

Journal of Managed Care & Specialty Pharmacy JMCP September 2018 Vol. 24, No. 9

www.jmcp.org
Opioid and benzo co-prescribing

APPENDIX A
Indicators of Potential Inappropriate Prescribing by Number of Individuals

[Bar chart showing the number of individuals with potential inappropriate prescribing from 2009 to 2014]

benzos = benzodiazepines; LA/ER = long acting/extended release

Journal of Managed Care & Specialty Pharmacy JMCP September 2018 Vol. 24, No. 9
www.jmcp.org
2016 opioid prescriptions per 100 persons (county)
U.S. unemployment by county
Figure 11. Deaths of Despair for White Non-Hispanics Age 50–54, by Level of Education, 1998–2015

Sources: National Vital Statistics System; authors’ calculations.

a. Deaths of despair refer to deaths by drugs, alcohol, or suicide.

Case and Deaton (2017) Brookings Papers on Economic Activity
Medical disability = safety net for poor/undereducated

SSDI 1957
- 150,000
- #1 reasons cancer and cardiac disease

SSDI 2016
- 8 million
- #1 reasons mental illness and musculoskeletal disorders

Karl Marx (1818-1883)

Religion is the opium of the masses.

(Karl Marx)

izquotes.com
#3 Cultural narratives
Pain is dangerous
“I look upon every ... effort calculated totally to subdue that pain and inflammation dangerous in the extreme .... for certainty a moderate degree of pain and inflammation in the extremities are the instruments which nature makes use of for the wisest purposes.”
The body cannot heal itself
Doctors have superhuman abilities to heal
Victimhood is a right to be compensated
Doctors (and patients) caught between a prescription and a hard place
ANXIETY

- stress
- fear
- worry
- emotional
- disorder
- sympton
- tension
- restlessness
- jumpy
- phobia
- panic attacks
- trembling
- desperate
- angst
Defense mechanisms to the rescue!
How defense mechanisms work

Anxiety →
Defense Mechanisms →
DECREASED ANXIETY
Denial
Projection
Splitting
Passive aggression
What happens when the compassionate doctor and the drug-seeking patient get a room?
Doctor meets patient Take 1
In other words . . .

A Kerfuffle that perpetuates the problem . . .
What happens when primitive defenses no longer work?

- For example when the Prescription Drug Monitoring Database shows undeniable doctor-shopping

- Doctor is fully unmasked as a de facto drug dealer
A narcissistic injury
Healthy narcissism

Heinz Kohut, *The Kohut Seminars*, 1987
Narcissistic rage and retaliation
How can we do better?

Enabling

Retaliation
The Opioid Epidemic Part II: What Hospitals and Doctors Can Do

Anna Lembke, MD
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What has been done so far?

- Pill Mills shut down
- Pain guidelines revised
- Hydrocodone products rescheduled/ Tramadol scheduled
- Naloxone distributed
- PDMPs re-invigorated
- Pharmacy lock-in programs implemented
- Opioid addiction treatment subsidized (CARA and 21st Century Cures Act)
- Abuse-deterrent formulations promoted (sketchy)
#1 Mandate prevention
Mandate checking the PDMP

Deborah Dowell, Kun Zhang, Rita K. Noonan and Jason M. Hockenberry; Mandatory Provider Review And Pain Clinic Laws Reduce The Amounts Of Opioids Prescribed And Overdose Death Rates; Health Affairs 35, no.10 (2016):1876-1883
10.1377/hlthaff.2016.0448
1 in 7 opioid naïve patients who refills an opioid Rx will become a persistent opioid user

1 in 7 patients who receive a refill or second opioid prescription were on opioids 1 year later. *Morbidity and Mortality Weekly Report (MMWR)* March 17, 2017/66(10); 265-269.
1 in 10 opioid naïve surgery patients will become a persistent opioid user

Following surgery, patients receive an average of 85 opioid pills, whether they need them or not.

Percent of Newly Persistent Opioid Patients

- Rotator Cuff: 10.2%
- Colectomy: 17.6%
- Sleeve Gastrectomy: 8.5%
- Hernia: 7.2%
- Total Hip: 9.9%
- Total Knee: 16.7%
- Hysterectomy: 7.5%

Overall: 9.5%

Share of Opioid Prescriptions by Gender

- Female: 65%
- Male: 35%

Newly persistent is defined as patients using an opioid far beyond (3-6 months) the postsurgical recovery period.

#2 Change the perverse incentives inside health care driving overprescribing
Eliminate patient satisfaction surveys
Reimburse providers for educating and spending time with patients, not just for pills and procedures.
Provide insurance coverage for non-medication alternatives for chronic pain
#3 Think of addiction ...

... as a chronic relapsing and remitting disease (even if you don’t believe it is one)
Biologizing problems is how we solve them
The disease model preserves compassion and reduces stigma
Over 90% of Nonfatal OD Patients Receive Post-OD Opioid Prescriptions

"Over a median follow-up of 299 days, opioids were dispensed to 91% of patients after an overdose. … Our finding that almost all patients continue to be prescribed opioids after overdose is highly concerning." Larochelle, et al., “Opioid Prescribing After Nonfatal Overdose and Association With Repeated Overdose,” *Ann Intern Med* 2016; 164:1-9, at 1, 6.
Build an infrastructure inside the house of medicine to treat addiction
Train doctors from the first day of medical school to detect and intervene for substance use problems
Treating addiction as a disease works

Drug Dependence, a Chronic Medical Illness
Implications for Treatment, Insurance, and Outcomes Evaluation

A. Thomas McLellan, PhD
David C. Lewis, MD
Charles P. O’Brien, MD, PhD
Herbert D. Kleber, MD

Many expensive and disturbing social problems can be traced directly to drug dependence. Recent studies estimated that drug dependence costs the United States approximately $67 billion annually in crime, lost work productivity, foster care, and other social problems. These expensive effects of drugs on all social systems have been important in shaping the public view that drug dependence is primarily a social problem that

The effects of drug dependence on social systems has helped shape the generally held view that drug dependence is primarily a social problem, not a health problem. In turn, medical approaches to prevention and treatment are lacking. We examined evidence that drug (including alcohol) dependence is a chronic medical illness. A literature review compared the diagnoses, heritability, etiology (genetic and environmental factors), pathophysiology, and response to treatments (adherence and relapse) of drug dependence vs type 2 diabetes mellitus, hypertension, and asthma. Genetic heritability, personal choice, and environmental factors are comparably involved in the etiology and course of all of these disorders. Drug dependence produces significant and lasting changes in brain chemistry and function. Effective medications are available for treating nicotine, alcohol, and opiate dependence but not stimulant or marijuana dependence. Medication adherence and relapse rates are similar across these illnesses. Drug dependence generally has been treated as if it were an acute illness. Review results suggest that long-term care strategies of medication management and continued monitoring produce lasting benefits. Drug dependence should be insured, treated, and evaluated like other chronic illnesses.

JAMA. 2000;284:1689-1695

www.jama.com
Enforce parity

MHPAEA

means

Mental Health Parity and Addiction Equity Act of 2008
Embrace opioid agonist treatment ... it works!
INPATIENT ADDICTION CONSULT SERVICE

Hospitalization is a critical opportunity to offer addiction diagnosis, treatment, and linkage to outpatient care. Addiction consult services decrease substance use, improve treatment adherence, and reduce readmissions.

**Evaluation and Diagnosis**
in patients with concern for substance misuse (i.e. drug-seeking, chronic high dose opioids, illicit drug use).

**Pharmacotherapy for Addiction**
- initiated inpatient with bridge prescriptions to outpatient follow up.
- Assistance with tapers for risky opioid and benzodiazepine use.

**Motivational Interviewing & Counseling**
- with education on treatment options, harm reduction, overdose prevention.

**Linkage to Outpatient Addiction Care**
- through coordination with outpatient providers, collaboration with social work, and discharge to outpatient programs.

*Consult Addiction Medicine (or page #14826)*
Available 8am - 5pm Monday - Friday
Stanford Perioperative Buprenorphine Protocol

**Pre-Surgery**
- Determine patient's daily buprenorphine dose; assess anticipated postoperative pain and opioid needs

**Buprenorphine Dose**
- Patients taking > 12 mg daily buprenorphine: taper to 12 mg in 2-3 days prior to surgery
- Patients taking ≤ 12 mg daily buprenorphine: continue this dose through entire perioperative period

**Day of Surgery**
- Continue 12 mg daily buprenorphine
- Multi-modal analgesia +/- regional anesthesia intraoperatively for pain management
- If prescribing opioids, use lowest dose for shortest duration

**Postoperative**
- Return to pre-operative buprenorphine dose as soon as possible
- Consider specialized pain service consult
- Reduce additional opioids as soon as possible

**Discharge**
- Continue daily buprenorphine dose at home
- Patient follows up with buprenorphine prescriber
The Bernese Method

Use of microdoses for induction of buprenorphine treatment with overlapping full opioid agonist use: the Bernese method

Robert Hämmig
Antje Kemter
Johannes Strasser
Ulrich von Bardeleben
Barbara Gugger
Marc Walter
Kenneth M Dürsteler
Marc Vogel

1Division of Addiction, University Psychiatric Services Bern, Bern, Switzerland; 2Division of Substance Use and Addictive Disorders, University of Basel Psychiatric Hospital, Basel, Switzerland

Background: Buprenorphine is a partial μ-opioid receptor agonist used for maintenance treatment of opioid dependence. Because of the partial agonism and high receptor affinity, it may precipitate withdrawal symptoms during induction in persons on full μ-opioid receptor agonists. Therefore, current guidelines and drug labels recommend leaving a sufficient time period since the last full agonist use, waiting for clear and objective withdrawal symptoms, and reducing pre-existing full agonist therapies before administering buprenorphine. However, even with these precautions, for many patients the induction of buprenorphine is a difficult experience, due to withdrawal symptoms. Furthermore, tapering of the full agonist bears the risk of relapse to illicit opioid use.

Cases: We present two cases of successful initiation of buprenorphine treatment with the Bernese method, i.e., gradual induction overlapping with full agonist use. The first patient began buprenorphine with overlapping street heroin use after repeatedly experiencing relapse, withdrawal, and trauma reactivation symptoms during conventional induction. The second patient was maintained on high doses of diacetylmorphine (i.e., pharmaceutical heroin) and methadone during induction. Both patients tolerated the induction procedure well and reported only mild withdrawal symptoms.

Discussion: Overlapping induction of buprenorphine maintenance treatment with full μ-opioid receptor agonist use is feasible and may be associated with better tolerability and acceptability.
#4 Reform disability
#5 Limit influence of special interest groups
#6 Provide alternative sources of dopamine

Dopamine $\text{C}_8\text{H}_{11}\text{NO}_2$
#7 Create De-Prescribing Clinics

http://stan.md/taper-off-opioids
Prescription Opioid Taper Support for Outpatients With Chronic Pain: A Randomized Controlled Trial

Mark D. Sullivan, Judith A. Turner, Cory DiLodovico, Angela D’Appolonia, Kari Stephens, and Ya-Fen Chan

Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, Washington.

Abstract: Patients receiving long-term opioid therapy for chronic pain and interested in tapering their opioid dose were randomly assigned to a 22-week taper support intervention (psychiatric consultation, opioid dose tapering, and 18 weekly meetings with a physician assistant to explore motivation for tapering and learn pain self-management skills) or usual care (N = 35). Assessments were conducted at baseline and 22 and 34 weeks after randomization. Using an intention to treat approach, we constructed linear regression models to compare groups at each follow-up. At 22 weeks, adjusted mean daily morphine-equivalent opioid dose in the past week (primary outcome) was lower in the taper support group, but this difference was not statistically significant (adjusted mean difference = -42.9 mg; 95% confidence interval, -92.42 to 6.62; P = .09). Pain severity ratings (0–10 numeric rating scale) decreased in both groups at 22 weeks, with no significant difference between groups (adjusted mean difference = -.68; 95% confidence interval, -.201 to .64; P = .30). The taper support group improved significantly more than the usual care group in self-reported pain interference, pain self-efficacy, and prescription opioid problems at 22 weeks (all P-values < .05). This taper support intervention is feasible and shows promise in reducing opioid dose while not increasing pain severity or interference.

Perspective: In a pilot randomized trial comparing a prescription opioid taper support intervention to usual care, lower opioid doses and pain severity ratings were observed at 22 weeks in both groups. The groups did not differ significantly at 22 weeks in opioid dose or pain severity, but the taper support group improved significantly more in pain interference, pain self-efficacy, and perceived opioid problems. These results support the feasibility and promise of this opioid taper support intervention.

© 2016 by the American Pain Society

Key words: Chronic opioid therapy, opioid dose taper, pain intensity, pain interference, pain self-management.
Figure 14-4: Discussing Prescription Opioid Dependence with Patients in the Primary Care Setting

B - Broaching the Subject
- Schedule enough time with your patient to have a discussion on this difficult topic
- Anticipate the patient’s strong emotional reaction
- Identify the feelings, normalize those feelings, and express empathy with the concerns the patient may have

R - Risk-Benefit Calculator
- When assessing benefits, weigh the patient’s pain relief against their functionality
- Involve family members for more objective views on a patient’s opioid use
- Track common risks such as tolerance and opioid-induced hyperalgesia
- Include all of these factors when discussing reasons for tapering off opioids

A - Addiction Happens
- Addiction is defined by the “Four C’s”: out-of-Control use, Compulsive use, Craving, and Continued use despite consequences
- Dependence happens when the body relies on a drug to function normally
- Dependence and Addiction are not equivalent

V - Velocity Matters - and So Does Validation
- Go slowly, take the necessary time to ease your patients down on their doses
- Let the patient be involved when deciding how much to decrease and at what time
- It is OK to take breaks in lowering the dosage
- Never go backwards; your patient’s tolerance will increase and progress will be lost

O - Other Strategies for Coping with Pain – teach patients these 3 Dialectical Behavioral Therapy (DBT) practices:
- STOP: Stop, Take a breath, Observe internal and external experiences, and Proceed mindfully
- Opposite Action Skills: acting opposite to a negative emotional urge in the service of pursuing values goals
- Radical Acceptance: accepting reality as it is and not as we wish it to be

http://stan.md/taper-off-opioids
BRAVO!
B = Broaching the subject
Recognize patients are terrified to come off opioids
Take more time, and get support
Donald Winnicott’s “holding environment”

“I’ve been thinking a lot about your chronic pain …”
R=Risk benefit calculator
R = Risk benefit calculator

- Side effects
- Pain relief
- Function
Side effects

- Depression
- Pseudo-dementia
- Constipation
- Hormonal imbalance
- Addiction
- Death
- Tolerance
- Dependence
- Withdrawal
- Hyperalgesia
Laura’ story

• On high dose opioids, Laura spent more and more time in bed.

• Her husband remarked she was “detached from family life.” Laura was not aware of being more detached.

• Her pain increased over time.
Involve family in risk assessment

- 2016 Washington Post Kaiser Family Foundation Survey of patients on chronic opioid therapy
  - 33% of patients worried about addiction
  - >50% of family members worried about addiction
Naloxone

Family Practice
123 Main Street | Anytown, USA

RX
Naloxone HCl 1mg/mL

2 x 2mL as pre-filled
Luer-Lock needleless syringe

2 x Intranasal Mucosal
Atomizing Device (MAD 300)

For suspected opioid overdose.
Spray 1mL in each nostril.
Repeat after 3 minutes if no or
minimal response.

MD

Signature
A = Addiction happens
What is addiction?

● The 3 “C’s”
  ○ Consequences
  ○ Control
  ○ Compulsion
Dependence vs addiction
Normalize the process of getting addicted
Tapering (*sometimes*) a litmus test for who is addicted?
Tell patients about treatment for opioid addiction before the taper.
Buprenorphine-naloxone
PDMP/UTox
Check your PDMP!

Deborah Dowell, Kun Zhang, Rita K. Noonan and Jason M. Hockenberry; Mandatory Provider Review And Pain Clinic Laws Reduce The Amounts Of Opioids Prescribed And Overdose Death Rates; Health Affairs 35, no.10 (2016):1876-1883
10.1377/hlthaff.2016.0448
### Prescription Drug Transaction Details:

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V = Velocity (and validate)
Mechanics

- Go slowly
- Start wherever the patient is willing to start
- Let the patient drive (within reason)
- Keep dosing schedule (BID, TID, etc)
- Take breaks
- Never go backwards
What to expect when you’re tapering

- Body fluids
- Psych symptoms (irritability, anxiety, insomnia, dysphoria)
- More PAIN!!!
- The pain of withdrawal “is not the pain you’ll have to live with when this is over.”
- Cancer treatment metaphor
Medications to tx withdrawal

- Clonidine 0.1mg QID x anticipated length of withdrawal. (Check BP & watch for hypotension)
- Diarrhea: Hyocosamine 0.125mg every 4-6 hours PRN
- Myalgias: Ibuprofen 400mg po QID or Acetaminophen 325mg po Q6hrs
  - Anxiety: Hydroxyzine 25mg po TID
  - Insomnia: Trazodone 50-300mg po QHS
- Nausea: Ondansetron 8mg po BID x anticipated length of withdrawal. (Check QTc)
- NO BENZOS!
O = Other treatments for pain
Opposite action

- Acting opposite to the emotional urge in the service of pursing values or goals.

- Encourage patients to do the opposite of dialing into pain, and instead, engage in activities, within reason, in spite of pain being present.
Radical Acceptance

• Radical acceptance is accepting reality as it is, not as we wish it would be.

• For chronic pain patients, this often means that their pain may likely never go away, but life can still be worth living even if it includes pain.
Reframing pain

- Pain as a source of creativity, compassion, gratitude, spirituality, meaning
Reinhold Niebuhr (1892-1971)

“Ultimately evil is done not so much by evil people, but by good people who do not know themselves and who do not probe deeply.”
Videos available free online

● Stanford University Online CME Courses
  https://med.stanford.edu/cme/learning-opportunities/online.html

● Youtube: Compassionate Doctor Meets Drug Seeking Patient: https://www.youtube.com/watch?v=SIJiMLxorkc

● Youtube: Drug Seeking Patient and Physician Interaction - Narcissistic Injury:
  https://www.youtube.com/watch?v=X9efr-5WAPc
Thanks for listening!
The decision to taper opioids

A. Should occur in every patient taking more than 120 MME’s daily
B. Should take into account adverse effects, pain relief, and functionality
C. Should only be initiated by the patient
D. Should occur in every patient who is opioid dependent
Increased pain during opioid withdrawal in chronic pain patients

A. Is a sign of the underlying pain disorder getting worse

B. Is an indication that the taper needs to be stopped and the dose raised again

C. Is likely to cause the patient only minimal discomfort

D. Requires reassurance that withdrawal-mediated pain is not a symptom of the underlying pain condition
True or False

● “The most opioids by volume in the United States are prescribed by a small minority of high volume prescribers, also known as pill mill doctors.”

● False
High patient satisfaction survey scores are associated with

● A. Improved clinical outcomes
● B. Decreased morbidity and mortality
● C. Decreased medication prescribing
● D. Increased mortality
The # of adults receiving SSDI

- A. Has increased more than twentyfold since 1957
- B. Has stayed about the same since 1957
- C. Is highest for patients with cancer and cardiac disease
Question

A 50 year old male patient, a former surgeon, presents to your office seeking a prescription for methylphenidate for his Attention Deficit Disorder. He is convivial and charming, and mentions you and he went to the same medical school and had many of the same teachers in common. You and he spend most of the visit chatting and reminiscing. At the end, you write a prescription for a month’s worth of methylphenidate. Later that day, the pharmacy alerts you to the fact that this patient has received identical prescriptions from three different doctors in the same day. This drug-seeking patient used which strategy to manipulate you.
Answer

● A. The Bully
● B. The Dynamic Duo
● C. The Exhibitionist
● D. The Twin