Opioids are among the world’s oldest known drugs and have been used for thousands of years for recreational and medicinal purposes. However, there is a growing problem in the US related to overprescribing opioids and prescription opioid abuse.

In the last 20 years, the number of opioid prescriptions written in the US has increased 400 percent. This increase is largely due to widespread use of opioids for management of chronic nonmalignant pain, such as back pain, myofascial pain, abdominal pain, and headaches.

The US is 5% of the world’s population, but consumes:

- 80% of the oxycodone (Percocet and OxyContin)
- 99% of the world’s hydrocodone (Vicodin)
- 65% of the world’s hydromorphone (Dilauded)
The term “opioids” includes both “opiates”—natural substances found in the resin of the opium poppy—and synthetic substances that resemble opiates.


Id.


The New York Times reports that doctors are prescribing opioids to pregnant women in “astonishing” numbers: 23 percent of the 1.1 million pregnant women enrolled in Medicaid filled an opioid prescription in 2007. Catherine Saint Louis writes, “Pregnant or not, Americans are simply pain-averse . . . It’s taboo to tell a patient it’s normal for you to be uncomfortable in pregnancy . . . You have to . . . understand the societal expectation in the US of the immediate resolution of pain.”

So What’s the Problem?

In short, addiction. Prescription opioid addiction brings the negative consequences of any addiction: crime, broken relationships, child abuse and neglect, and poverty. It also causes crossover heroin use and addiction and overdose deaths caused by both prescription and street drugs.

Seventy-five percent of heroin users report that they started out by using prescription opioids. Opioid addicts turn to heroin because it is one-fifth of the cost and widely available. US deaths from both prescription opioid and heroin overdoses are rising dramatically:

These numbers demonstrate that overprescribing opioids—like underprescribing—causes suffering. Is there a solution?

HISTORY

Opium and its derivatives have been produced and marketed as medicines and as recreational drugs throughout Asia for centuries.

In early- and mid-Victorian England, opium preparations could be purchased in a chemist’s shop and from traveling salesmen as a “cure all” to treat pain, coughs, rheumatism, diarrhea, vomiting, hiccups, pleurisy, cardiac disease, and “women’s troubles.” Opium mixed with molasses was marketed as “Mother’s Friend” and given to babies and young children to keep them quiet! Recreational use was popular with writers and artists.

Optimism surrounded the early use of morphine. It was used liberally during the Civil War; it delivered effective pain relief, but many soldiers developed dependence and addiction.

By the early twentieth century, doctors began to warn about the dangers of addiction. The United States recognized the need to regulate narcotics and began to enact drug-related laws.

Too Little Opioid Use?

Increased restrictions related to recreational and medicinal opioids resulted in decreased opioid use. This was the hoped-for outcome, but it came with the unintended consequence of undertreatment of pain in terminally ill patients. Dame Cicely Saunders of England launched the modern hospice movement in the 1960s with a focus on providing adequate pain relief for patients near death.
The Tide Turns

Healthcare professionals began to recognize that undertreated pain causes unnecessary physical and psychological suffering as well as longer hospital stays and higher healthcare costs.

- A 1980 letter to the *New England Journal of Medicine* cited a low addiction rate among patients prescribed opiates and spurred a growing movement within medicine to treat pain more aggressively.\(^{11}\)
- In 1995, the American Pain Society designated pain as the “fifth vital sign” that needed to be assessed in order to better treat pain.\(^{12}\)
- A “slow release” opioid (OxyContin) was introduced in 1996 and aggressively marketed to physicians as having a lower risk of abuse and addiction (not true).\(^{13}\)
- The Joint Commission received ongoing reports of inadequate pain control for postoperative and trauma pain, cancer pain, and other acute and chronic pain challenges and instituted pain management standards in 2001.\(^{14}\)
- The CMS Conditions of Participation provide a patient with the “right” to participate in the development and implementation of his or her “pain management plan.”\(^{15}\)

Government Response

The Executive Office of the President of the United States issued this report in 2011: “Epidemic: Responding to America’s Prescription Drug Abuse Crisis.” The government’s plan includes:

- Education.
- Tracking and monitoring.
- Proper medication disposal.
- Enforcement.\(^{16}\)

The President’s report notes that most physicians receive little training on the importance of appropriate prescribing and dispensing of opioids to prevent adverse effects, diversion, and addiction. The government recommends education for healthcare providers in these areas.

The government also advises better tracking and monitoring of narcotic prescriptions and encourages states to establish prescription drug monitoring programs to detect and prevent abuse of prescription drugs at the retail level (“doctor shopping”). Forty-nine states (all except Missouri) have a prescription drug monitoring program; these programs are mandatory in only 16 states.\(^{17}\)

Citing a 2009 National Survey on Drug Use and Health, the President’s report notes that more than 70 percent of people who use prescription pain relievers nonmedically get them from friends or relatives. Therefore, proper disposal of unused, unneeded, or expired medications is a key strategy.

The report recognizes that a small group of healthcare practitioners prescribe outside the usual course of professional practice or for illegitimate purposes. The government intends to continue aggressive enforcement actions against “pill mills.”

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Support the use of prescription drug monitoring programs. Are you familiar with your state program? If your state has a mandatory program, are your providers compliant? Do they understand how to use the program? If your state program is voluntary, encourage your providers to participate in the program—or make it mandatory. (Missouri: Support prescription drug monitoring program legislation.)

Require provider education. Providers of all specialties need to learn more about pain management, safe opioid prescribing, and addiction. The FDA requires drug manufacturers to develop education for providers but does not require providers to participate in education. Make education mandatory for your providers so they have the information they need.

Follow evidence-based treatment guidelines. Treatment guidelines will help you and your providers recognize and implement best practices related to opioid prescribing. Find out whether your providers follow these or other evidence-based guidelines:

- American Pain Society—Clinical Practice Guidelines (eight published guidelines, additional guidelines to be published in 2015; http://americanpainsociety.org/education/guidelines/overview)
- State medical board guidelines (e.g., http://mn.gov/health-licensing-boards/medical-practice/licensees/practice/pain-mgmt-guidelines.jsp)

Conclusion

Over- and underprescribing opioids causes pain and suffering. Prescription drug monitoring programs, provider education, and evidence-based treatment guidelines can help. Educate and engage your providers to use the tools available to find a balanced approach to prescribing opioids.