



# The Opioid Epidemic

## Finding a Better Prescription for Chronic Pain

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Opioid-related deaths are continuing to escalate. Sixty-one percent of all narcotic-related deaths are results of both licit (prescribed) and illicit use of opioids. This is more than three deaths per hour in the United States.<sup>1</sup> The fastest-growing death rates are for whites ages 25 to 34 and whites 35 to 44 years old, rising five- and threefold respectively since 1999. These numbers include both prescribed and illegal drugs.<sup>2</sup>

In 2012, we addressed many of the failures in our workers' compensation systems that permit unnecessary prescriptions in "[Opioids Wreak Havoc on Workers' Compensation Costs](#)." The advice remains fundamentally solid. What we didn't address were the broad underlying causes for this behavior. Recent advances in science now make that possible.

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<sup>1</sup>Increases in drug and opioid overdose deaths – United States, 2000-2014. MMWR Early Release; December 18, 2015. <http://mmwr.cdc.gov/mmwr>.

<sup>2</sup>[http://www.nytimes.com/2016/01/17/science/drug-overdoses-propel-rise-in-mortality-rates-of-young-whites.html?smid=nytcore-ipad-share&smprod=nytcore-ipad&\\_r=0](http://www.nytimes.com/2016/01/17/science/drug-overdoses-propel-rise-in-mortality-rates-of-young-whites.html?smid=nytcore-ipad-share&smprod=nytcore-ipad&_r=0).





There have been major advances that explain the “why” of opioid overprescribing and the escalating frequency of accidental deaths from these controlled substances. Pain complaints, both in workers’ compensation and public health, are the leading reason for medical visits. The most common pain complaints are musculoskeletal, with back pain being the most common of these.<sup>3</sup>

Opioids and cocktails containing opioids combined with muscle relaxants, anti-anxiety, anti-convulsant, and sleep medications are used exclusively to address both acute and chronic pain. This may result in long-term overprescribing. Several states are working to abate the adverse consequences, in particular, death from prescribed opioids. Since 2012, ten additional states have joined the four who already have closed formularies for workers’ compensation, which substantially control the unnecessary prescribing of narcotics that treat acute and chronic pain. This trend is expected to continue and gain momentum.

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Since 2012, there has been a plethora of published research addressing chronic pain, especially in workers’ compensation claims, with pointed attention to “why” the underlying reasons for such pain are being largely unaddressed.

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<sup>3</sup>Deyo, R., et al. Overtreating chronic back pain: time to back off?. JABFM, January-February 2009; Vol. 22, No. 1.

Opioids, and chronic opioid therapy, are typically used to treat chronic pain (pain lasting more than three months or past the time of normal tissue healing). Unfortunately, contrary to medical treatment guidelines, approximately one-third of workers off work with new low-back injuries receive opioids during the first six weeks after injury and usually at the first visit. Research suggests that receiving two opioid prescriptions during this early time frame is associated with a doubling of the risk of disability at one year.<sup>4</sup>

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In 2013, the AMA Guides<sup>5</sup> stated that “Long-term narcotic usage reliably causes worsening of pain, and often more harm than good, for chronic-benign-pain patients. Since narcotic intake creates an artificially severe pain level, and perhaps resultant impairment, a patient receiving narcotics cannot credibly be considered to have reached maximum medical improvement (MMI) or be ratable, because any impairment may not be permanent.”

<sup>4</sup>Franklin, G., et al. Workers’ compensation: poor quality health care and the growing disability problem in the united states. American Journal of Industrial Medicine. 2014, Wiley Periodicals, Inc.

<sup>5</sup>Barth, R., Chronic Pain: Fundamental Scientific Considerations, Specifically for Legal Claims. American Medical Association Guides Newsletter. January/February 2013.

Pain experience is a complicated brain-based combination of tissue tenderness, emotions, psychological, and learned behaviors.



The question that could not have been adequately addressed in 2012 is now being answered with abundant clarity. The Institute of Medicine, the AMA, the American Academy of Pain Management, the American Academy of Orthopedic Surgeons, and many more have published in the medical literature, research that the pain experience is a complicated brain-based combination of tissue tenderness, emotions, psychological, and learned behaviors. The dentist visit really does hurt more if the patient is afraid. It's not just about the tooth. Yet physicians are trained to focus almost exclusively on the physical-sensory (tissue) component of this very complex multi-factored problem. Continued and escalated doses of opioids are prescribed, more unnecessary spinal injections or surgery is performed, yet the patient fails to improve. This is no longer considered an acceptable approach to addressing pain and the outdated biomedical model of pain management has now been replaced by the bio-psychosocial pain management model.

Newer research is consistent in its discussion of how the psychiatric and emotional experience is actually predictive of which patients, early in their injury cycle, will experience chronic pain by the presence of personality disorders and other mental health conditions such as anxiety and depression.<sup>6, 7, 8</sup>



**See Lockton's White paper:**  
**Red Herrings and Medical Overdiagnosis Drive Large-Loss Workers' Compensation Claims**

## Why are physicians not responding to this new pain management model?

The Institute of Medicine (IOM) has addressed this concern in its statement that “healthcare professionals are not well educated in emerging clinical understanding in pain prevention and treatment.”<sup>9</sup> States mandating closed formularies are addressing the immediate issue of overprescribing narcotics to treat pain but are still failing to address the underlying cause of the problem. As recently as 2014, it is still concluded that “opioids may be used in current clinical practice as the de facto and only psychiatric treatment for patients with chronic pain, despite little evidence for sustained benefit.”<sup>10</sup>

As we communicated in our [2015 White Paper on Medical Overdiagnosis](#), there are now behavioral pain assessments, in the form of no-cost questionnaires, that may easily be conducted with claimants exhibiting early signs of chronic pain. Where assessments demonstrate the potential of delayed recovery, new technologies such as NeuroPAS Global's Neurophysiological Pain Profile, may be used. This new technology identifies the physical and nonphysical components of the patient's pain experience. Frequently, this information leads to effective care without the need for chronic opioids and debilitating medications.

Much has changed in the last three years to more fully understand the opioid-prescribing conundrum. Focusing on the underlying causes of overprescribing is the desired path for employers.

<sup>6</sup>Global Spine Journal Vol. 5; Vol. 6/2015.

<sup>7</sup>Rosenblum, K., Ross, D., Christian, J. Red herrings and medical overdiagnosis drive large-loss workers' compensation claims. February 2015. Lockton Companies.

<sup>8</sup>Barth, R. Evaluating claims of injury relatedness, work-relatedness, accident-relatedness, etc.; Summary of the method from the American medical association's AMA guides to the evaluation of disease and injury causation currently in its second edition, copyright 2014.

<sup>9</sup>Institute of Medicine (US) Committee on Advancing Pain Research, Care and Education. Relieving Pain in America: A blueprint for transforming prevention, care, education, and research. National Academies Press (US); Washington, DC. 2011

<sup>10</sup>Howe, C., Sullivan, M. The missing 'P' in pain management: how the current opioid epidemic highlights the need for psychiatric services in chronic pain care. General Hospital Psychiatry. Jan-Feb 2014; 36(1):99-104.