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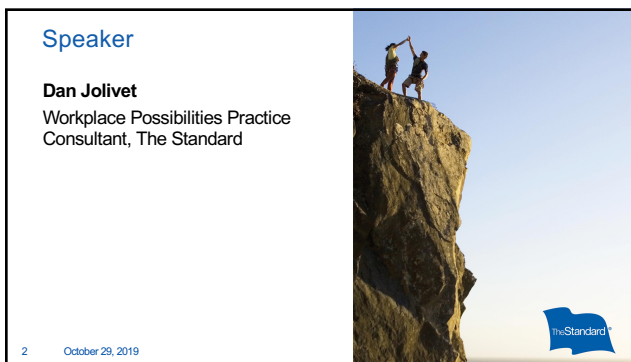
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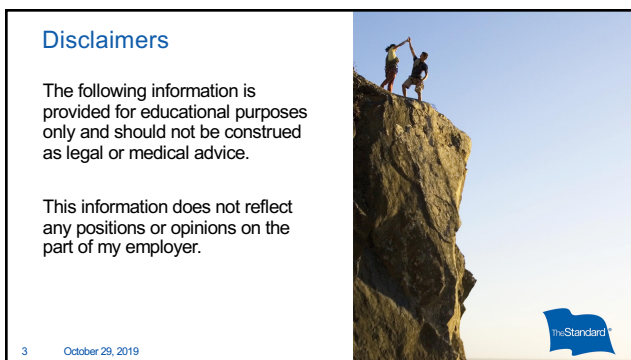
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### Agenda

- The History of Opium Use
- Understanding Pain and Pain Management Options
- Treatment with Opioid Pain Medication
- The Current Opioid Epidemic
- Opioid Addiction
- Working with the People on Opioid Medications

4 October 29, 2019



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### Goals of this training

Attendees at this training will:

1. Gain an understanding of the causes of the current opioid crisis in the US;
2. Learn about appropriate treatment options for opioid use disorders;
3. Develop an awareness of the neurological processes associated with pain;
4. Relate the neurological processes associated with pain to how pain management strategies can help; and
5. Acquire specific case management strategies for working with clients on opioid medication.

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### The History of Opium Use

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**Opium was one of the first drugs discovered**

- 3,400 BC – Cultivated in Mesopotamia
- Mentioned in Homer's **Odyssey** and the **Bible**
- 1676 - Laudanum, a tincture of opium, was introduced as a treatment for pain, coughing & diarrhea
- 1803 - Morphine was first isolated from opium
- 1821 - **Confessions of an Opium Eater** by Thomas De Quincey
- 1832 - Codeine was first isolated from opium

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**Opioids have been used both recreationally and medicinally throughout history**

- 1839 to 1860 – Britain fought in China to keep opium legal in the Opium Wars
- 1849 – Opium dens become popular in the US following the Gold Rush
- 1874 – Heroin was first derived from morphine
- 1897 – Heroin is independently resynthesized by Felix Hoffmann of Bayer
- 1898 – Bayer begins selling Heroin as a cough suppressant, particularly for children, continuing through 1910

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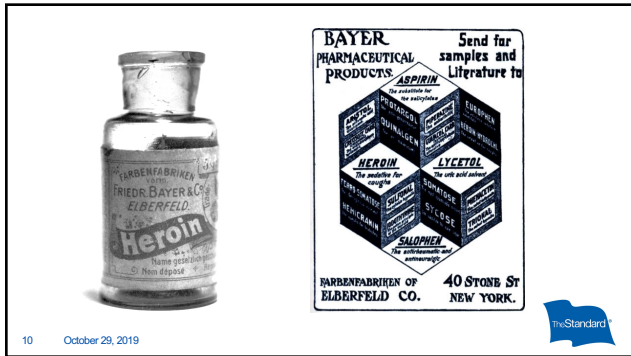
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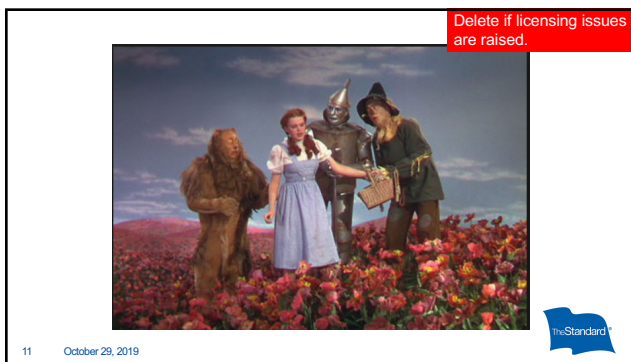
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**Opioids have been a focus of both drug research and anti-drug social campaigns**

- 1914 – The Harrison Narcotics Tax Act restricted the distribution and sale of opium, Heroin, and cocaine
- 1916 – Oxycodone was first manufactured
- 1920 - Hydrocodone first manufactured
- 1924 – The Anti-Heroin Act made it illegal to make, import or sell Heroin in the US
- 1937 – Methadone was first synthesized
- 1960 - Fentanyl was first made

A small blue logo for 'The Standard' is in the bottom right corner.

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**Understanding Pain and Pain Management Options**

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**Pain is the Leading Reason for People Seeking Medical Care in the US**

- Estimated cost to the US economy: 635 billion per year
- Any pain lasting more than 12 weeks is considered chronic
- Chronic pain impacts approximately 20% of American adults
- Chronic pain is more common among:
  - Women
  - Older adults
- 8% report pain that limited at least one major life activity

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**Risk Factors for Chronic Pain**

- Behavioral health disorders
- Multiple physical disorders
- Smoking
- Alcohol use
- Obesity
- Limited physical exercise
- Poor sleep
- Poor nutrition

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### Pain occurs in 5 phases

1. Transduction: This is the neural activity (AP or Action Potential) that occurs at the site of the painful stimulus
2. Conduction: This is the movement of the neural activity from the peripheral process to the central process (CNS)
3. Transmission: The neural activity generates an AP through the spinothalamic tract to the brain
4. Modulation: The AP can be either facilitated or suppressed dependent on other conditions important to the organism
5. Perception: Pain is a complex integration of sensations, emotions and thoughts

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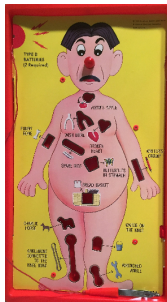
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### Pain occurs in 5 phases



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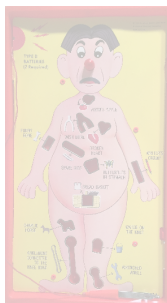
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### Pain occurs in 5 phases



- ← Perception
- ← Modulation
- ← Transmission
- ← Conduction
- ← Transduction

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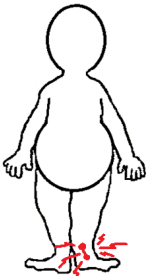
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**Pain occurs in 5 phases**

To use if licensing issues are raised.



- ← Perception
- ← Modulation
- ← Transmission
- ← Conduction
- ← Transduction

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19

**A Quick Note on Substance P**

Substance P is a neuropeptide that is released from the terminal buttons of specific sensory neurons found in the brain and spinal cord. It functions as both a neurotransmitter and a neuromodulator.

It is associated with the inflammation process and with the perception of pain.

It is also implicated in various mood disorders, including anxiety and stress.

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**There are 4 main ways to manage pain**

1. Preventing transduction at the site of the pain (topical anesthetics, NSAIDs, antihistamines)
2. Interrupting transmission of the AP from the site of the pain to the brain (local anesthetics, epidural block)
3. Suppressing the AP via modulation, either via medications (spinal opioids, NSAIDs) or alternative medicine strategies (acupuncture, self-hypnosis/meditation)
4. Modifying the perception of pain, either through medication (parental opioids, general anesthesia) or a focus on the emotional and cognitive aspects of it

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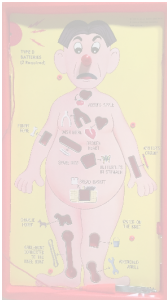
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**Pain occurs in 5 phases**



- ← Perception - Modify
- ← Modulation - Suppress
- ← Transmission - Interrupt
- ← Conduction - Interrupt
- ← Transduction - Prevent

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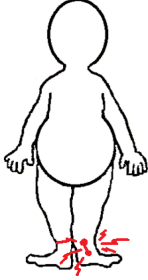
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**Pain occurs in 5 phases**

To use if licensing issues are raised.



- ← Perception - Modify
- ← Modulation - Suppress
- ← Transmission - Interrupt
- ← Conduction - Interrupt
- ← Transduction - Prevent

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**The Autonomic Nervous System is Made up of the Sympathetic and Parasympathetic Systems**

- Sympathetic Nervous System (SNS)
  - Fight or Flight
  - Pain generally involves the SNS
- Parasympathetic Nervous System (PNS)
  - Feed & Breed
  - Rest & Digest

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### The Sympathetic and Parasympathetic Systems are mutually antagonistic

- The SNS and PNS are mutually modulating
  - Activating one suppresses the other
  - Activating the PNS via deep breathing, mindful meditation or self-hypnosis suppresses the transmission of pain via the SNS and modulates the perception of pain

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### Chronic Pain Syndrome

Chronic Pain Syndrome (CPS) is a condition in which complications of the illness or injury that initially caused the pain lead to ongoing pain in a vicious circle. For example, the initial pain can lead to problems with diet, exercise, sleep, work, interpersonal relationships, frustration tolerance and normal activities, leading to increased stress, inflammation, activation of the Sympathetic Nervous System (SNS), upward modulation of pain perception, and a positive feedback loop in which pain creates stress which intensifies and prolongs pain.

The key is to break the cycle.

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### Chronic Pain Syndrome Involves Several Vicious Circles

Pain impacts every aspect of the person's life, but it may be most useful to focus on five key areas:

1. Sleep
2. Mood
3. Physical Activity
4. Nutrition
5. Thinking

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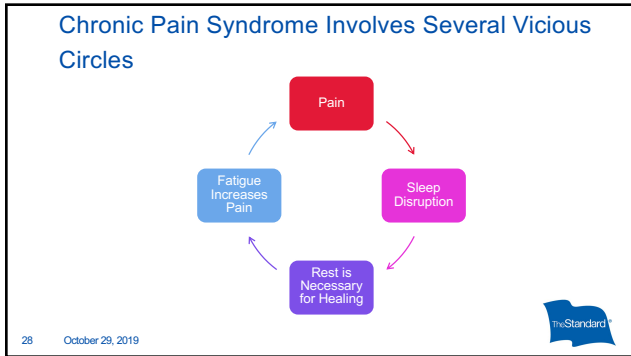
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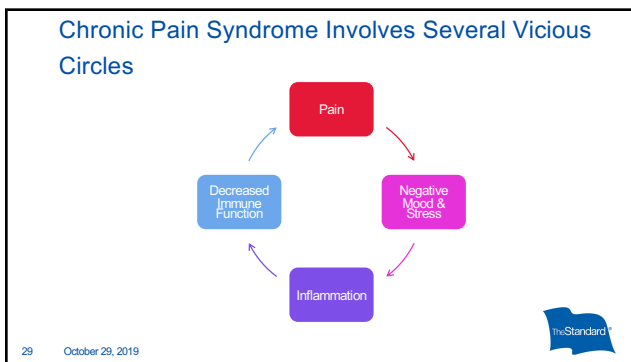
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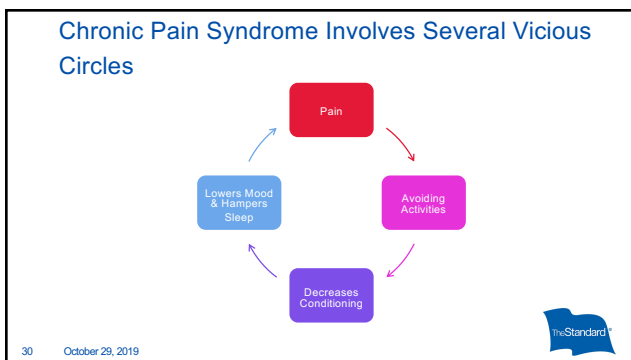
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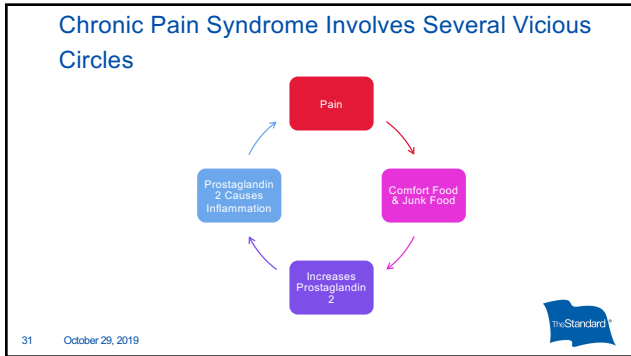
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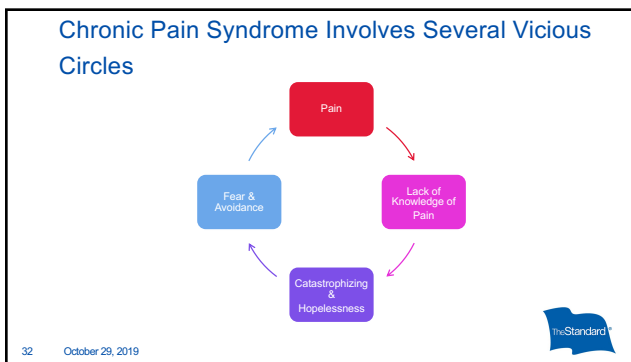
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### Treatment at a Pain Management Clinic

Pain management clinics generally utilize a multidisciplinary approach with several therapies simultaneously to address pain, including:

- Medication
- Physical Therapy and Exercise Recommendations
- Occupational or Vocational Therapy
- Psychological Interventions
- Dietary or Nutritional Consultations
- Alternative Therapies

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**"If exercise could be packed into a pill..."**

"...it would be the single most widely prescribed and beneficial medicine in the nation."

**What we do—and don't—know about exercise**  
*Harvard Women's Health Watch*  
January 2016

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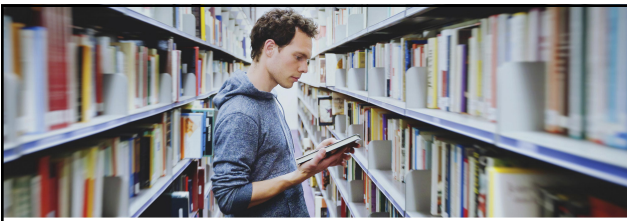
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**Treatment with Opioid Medications** 

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**Opioids act on opioid receptors throughout the Central Nervous System (CNS)**

- Opioid receptors are also found in peripheral tissue, both neural and non-neural
- Opioids mimic the action of naturally occurring endogenous opioid peptides
- Specific opioids can act as agonists, antagonists or partial agonists at these receptors
- The effect of stimulating a receptor depends on numerous factors, including the location of the receptor

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**On a cellular level, opioids have several main actions**

- They close some calcium channels and open inwardly-rectifying potassium channels
- This results in hyperpolarization of the neuron and a reduction in neuronal excitability
- They also decrease intracellular cAMP, modulating the release of nociceptive neurotransmitters, including substance P

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**Different opioid receptors produce different functional effects**

- Stimulating the MOP receptors causes analgesia, sedation, depressed respiration, slowed heartbeat (bradycardia), nausea, vomiting and a decrease in gastric motility
- Stimulating the DOP receptors can cause spinal & supraspinal analgesia, along with decreased gastric motility
- Stimulating the KOP receptors can cause spinal analgesia, urine production (diuresis), and dysphoria.

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**The effect at the MOP receptors causes most of the analgesic effect**

- Actions at other receptors cause other effects, including:
  - Reduced consciousness
  - Euphoria
  - Reduced respiration
  - Constipation
  - Nausea
  - Vomiting
  - Urinary retention
  - Pruritis
  - Muscular rigidity
  - Miosis
  - Dysphoria

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There are at least two mechanisms of action for the opioid analgesic effects

- Within the Central Nervous System, some opioids activate descending inhibitory pathways and neurons
- Others directly inhibit nociceptive afferent neurons, reducing the transmission of pain signals from the periphery
- WebMD: "Opioid drugs bind to opioid receptors in the brain, spinal cord, and other areas of the body. They tell your brain you're not in pain."

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Opioids are most effective for cancer pain and end-of-life treatment

1. Effectiveness has been proven for short- and medium-term use, but not long-term use; the longest drug trials to date have been for less than one year.
2. Although opioids have been shown to reduce chronic, non-cancer pain and to improve patient physical functioning, the improvements are generally small and not clinically significant.
3. The high potential for harm (including addiction, overdose & death) suggests opioids should not be the first choice for treatment of chronic non-cancer pain.

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Opioids are most effective for cancer pain and end-of-life treatment

4. Although there are methodological issues with the studies, the evidence to date suggests that opioid pain medications are generally not more effective than other pain medications for non-cancer pain.
5. Studies with longer follow-up periods reported less pain relief with opioid pain medications.
6. Most patients who are prescribed opioid medications for chronic non-cancer pain will not experience clinically significant benefits.

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### Opioid Prescriptions are Highly Dependent on Geography

Variations in opioid prescription rates vary depending on the location of the prescribing provider, more than on the injury type, severity, or other factors that would be expected to determine opioid prescription use.

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### Opioid Prescriptions are Associated with Negative Outcomes for Workers Compensation

People on Workers Compensation disability leave who were prescribed opioid pain medication:

- Had longer disability durations – three times as long for people on prolonged opioid medication.
- Were three times as likely to undergo surgery for the initial injury.

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### CDC Guidelines for Prescribing Opioids for Chronic Pain

Released in 2016, the CDC Guidelines include the following:

1. Opioids are not first-line therapy
2. Establish goals for pain and function
3. Discuss risks and benefits
4. Use immediate-release opioids when starting
5. Use the lowest effective dose
6. Prescribe short durations for acute pain

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### CDC Guidelines for Prescribing Opioids for Chronic Pain

7. Evaluate benefits and harms frequently
8. Use strategies to mitigate risk
9. Review Prescription Drug Monitoring Program (PDMP) data
10. Use urine drug testing
11. Avoid concurrent opioid and benzodiazepine prescribing
12. Offer treatment for opioid use disorder

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### The Federation of State Medical Boards Guidelines for the Chronic Use of Opioid Analgesics

Adopted in 2017, these are somewhat more restrictive than the CDC guidelines and include:

- A greater focus on risk stratification;
- Assessment for possible behavioral health disorders, especially substance use disorders;
- Including information from family members and/or significant others;

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### The FSMB Guidelines for the Chronic Use of Opioid Analgesics

These also recommend negotiating a treatment agreement as part of the informed consent process, with the following elements:

- Treatment goals
- Patient's responsibility for safe medication use
- Secure storage and safe disposal
- Patient's responsibility to obtain prescribed opioids from only one clinician or practice, and filling prescriptions at only one pharmacy
- Patient's agreement to periodic drug testing

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### Common opioid pain medications

Medication Name	Morphine Equivalent Units
Meperidine	0.10
Tramadol	0.10
Codeine	0.15
Tapentadol	0.40
Hydrocodone	1.00
Morphine	1.00
Oxycodone	1.50
Methodone	3.00
Oxymorphone	3.00
Hydromorphone	4.00
Fentanyl	2,400

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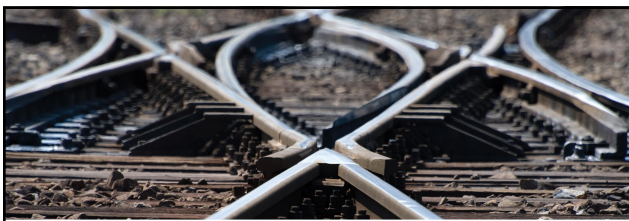
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### The Current Opioid Crisis

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### The current opioid crisis was primarily fueled by marketing campaigns

- 1996 – Purdue Pharma introduced OxyContin, a sustained-release oxycodone preparation
  - Marketed initially for treating moderate to severe cancer pain
  - Suggested that “less than 1%” of patients treated with opioids become addicted
  - Produced the video “From One Pain Patient to Another” in 1997
  - In 1998, began marketing for arthritis and low back pain

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The current opioid crisis was primarily fueled by marketing campaigns

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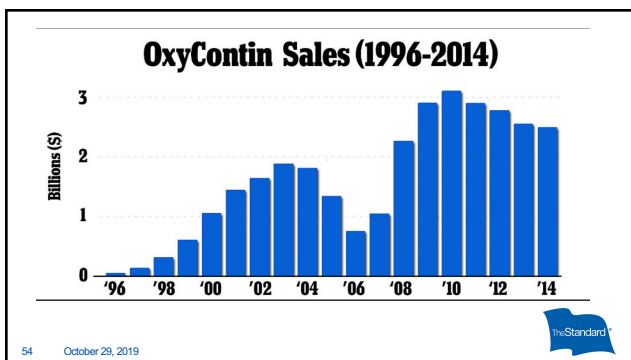
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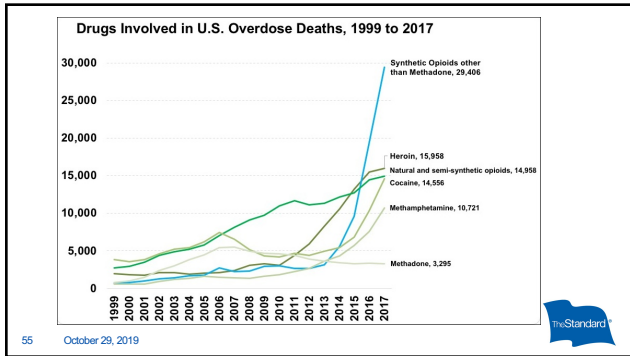
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**There have been three stages to the crisis, so far**

Over time, different factors have contributed to the crisis:

- 1999 on: Prescription opioid abuse and overdose deaths associated with natural and semi-synthetic opioids.
- 2010 on: The crackdown on prescription opioids led to an increase in Heroin use and overdose deaths.
- 2014 on: The crackdown on Heroin use led to an increase in the use of synthetic opioids, primarily fentanyl.

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**The fourth stage of the crisis?**

Preliminary data for 2018 suggest an increase in use and overdose associated with combinations of other illicit drugs with fentanyl:

- "Speedball" – Used to be Heroin & cocaine; now fentanyl & cocaine.
- "Goofball" – Used to be methamphetamine & cocaine; now fentanyl & methamphetamine.
- Since fentanyl is so much more potent than Heroin, these combinations are much more dangerous and more likely to lead to overdose & death.

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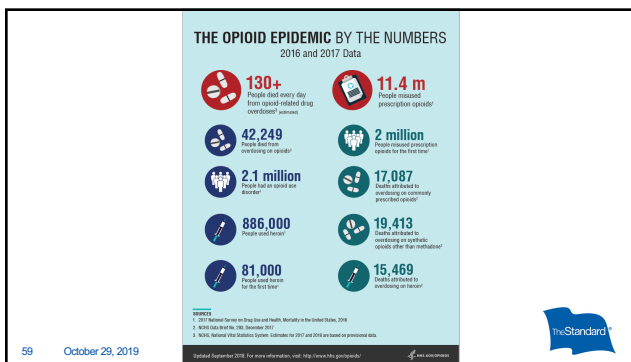
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**The Opioid Crisis and the Suicide Crisis**

The United States has seen a dramatic increase in suicides since 1999, with an overall increase of 33% through 2017.

- It is often impossible to clearly determine whether an overdose was accidental or intentional, especially if there is no suicide note.
- A survey of people who misuse prescription opioids reported suicidal ideation 40-60% more than others with similar health & psychiatric conditions, and were twice as likely to attempt suicide as people who don't misuse those medications.
- Estimates of the percentage of overdoses that were really suicides range up to 30%.

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There have been subsequent legal actions to address this inappropriate marketing

- 2007– Purdue Frederick Company, Inc. and 3 top executives pled guilty to criminal charges of misbranding OxyContin by claiming it was less addictive than other opioids
  - They agreed to \$634 million in fines
- 2010 – The US government began cracking down on doctors who were overprescribing opioids
  - An unintended consequence of this was people who were addicted to prescription medication turned to Heroin
- 2017 - The US President declared the opioid epidemic a "National Emergency."

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Outcomes of recent legal actions include:

- March 26, 2019 - *Oklahoma v. Purdue Pharms* – Purdue settled for \$270 million.
- June 3, 2019 – *West Virginia v. McKesson Corporation* – McKesson settled for \$37 million.
- August 6, 2019 – Drug distributors AmerisourceBergen, Cardinal Health & McKesson offered to settle a lawsuit brought by the National Association of Attorneys General on behalf of 35 states for \$10 billion. The NAAG countered with a demand for \$45 billion.
- August 26, 2019 – *Oklahoma v. Johnson & Johnson* – J&J ordered to pay \$572 million.

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Outcomes of recent legal actions include:

- September 11, 2019 – Purdue Pharma reaches a tentative deal in the *National Prescription Opioid Litigation* case, involving 23 states and more than 2,000 cities & counties, declaring bankruptcy and offering approximately \$12 billion.
- The *National Prescription Opioid Litigation* case is still pending with other pharmaceutical companies, drug distributors and drugstores (such as CVS, Rite Aid, Walmart & Walgreens).

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**Opioid Addiction**

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**Opioids are highly addictive**

- They are associated with significant tolerance effects – it takes more & more to get the same effect
- Users may experience cravings for them – a strong urge to use them and this may result in failed attempts to cut down or control use
- Stopping use leads to significant withdrawal – this leads users to take actions in order to maintain their use
- Along with the direct effects of the drugs, these may lead to social problems, risky or illegal behavior, and continued use despite clear problems

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**Despite this, treatment of opioid addiction is very often successful**

Treatment may occur in:

- An inpatient setting for detoxification or rehabilitation
- Partial Hospital Program (PHP) or Intensive Outpatient Program (IOP) levels of care for substance use disorders
- Residential Treatment Center (RTC) settings to facilitate a transition to sober living
- Outpatient treatment
- Support groups

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Evidence-based approaches to opioid addiction include the following

- Cognitive Behavioral Therapy (CBT)
- Medication Assisted Treatment (MAT) combining a behavioral therapy with medication to support abstinence
  - Methadone – opioid agonist that does not block other narcotics
  - Naltrexone – non-addictive opioid antagonist that blocks the effects of other narcotics
  - Buprenorphine – opioid agonist/antagonist that reduces withdrawal symptoms while blocking other narcotics
  - Suboxone – a medication combining naltrexone & buprenorphine

67 October 29, 2019



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67

A Quick Comment on Methadone

According to a review by the World Health Organization, "...substitution therapies such as methadone are still the most promising method of reducing drug dependence.."

It is less dangerous during pregnancy, reduces crime, increases employment, and improves quality of life amongst users.

However, it's not a wonder drug and there are issues with its use, such as a very high rate of domestic violence/

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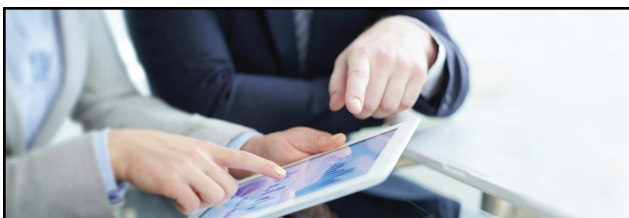
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Working with People on Opioid Medication

October 29, 2019



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### The Foundation for Working with People on Opioid Medications is What You Already Know

When working with people on opioid medications, you will rely on what you already know about helping people who are in pain, such as:

- Vocational Rehabilitation approaches such as:
  - Transferrable Skills Analysis (TSA);
  - Physical Demand Analysis;
  - Job Profiling;
  - Job matching;
  - Work Hardening;
  - Work Conditioning;
  - Return to Work Management; and
  - Career Counseling.

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### The Foundation for Working with People on Opioid Medications is What You Already Know

- Training the person to:
  - Maintain neutral posture;
  - Work in their comfort zone;
  - Take breaks as necessary to move and stretch;
  - Avoid excessive force;
  - Reduce excessive motions;
  - Minimize contact stress;
  - Reduce excessive vibration; and
  - Provide adequate lighting.
- Identifying appropriate accommodative equipment.

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### The Foundation for Working with People on Opioid Medications is What You Already Know

- Occupational Therapy approaches such as:
  - Proactive pain control strategies such as the use of heat or cold;
  - Neuromuscular re-education to train the person to use the appropriate muscle groups to perform tasks;
  - Muscle tension reduction training;
  - Assertiveness training;
  - Proactive problem solving;
  - Developing a home exercise program; and
  - Pacing activities.

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### When Talking with Someone Using Opioid Pain Medications, What You Say Matters

People who are on opioid pain medications are frequently sensitized to specific messages, so you need to be careful to use language that doesn't trigger a negative response.

**Don't Say...**

- "It's all in your head."
- "Your tests results are all fine."
- "You need to relax."
- "You don't need to worry."
- "You need to exercise."

**Instead, Say...**

- "Pain is complicated."
- "Tests don't measure pain."
- "Managing stress can help pain."
- "You're sore, but you're also safe."
- "Movement helps over time."

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### "If you don't know where you're going, you might not get there"

Attributed to Yogi Berra

Evidence-based approaches include goal-directed treatment such as Motivational Interviewing.

- As part of your assessment, review their prescription history and see if you can tell whether the prescriber(s) are following the CDC or other guidelines for prescribing opioids.
- If you use the "Typical Day" question as part of your assessment, consider how the person discusses their pain and/or their medication use.
- When asking about the person's goals, you may need to have them refocus from what they want less of (such as less pain) to what they want more of.

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### WHAT IS YOUR GOAL FOR CASE MANAGEMENT?



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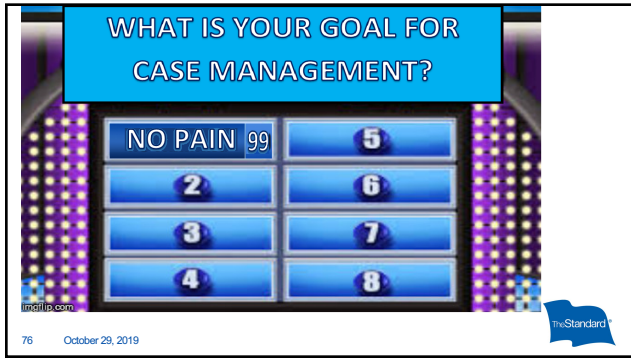
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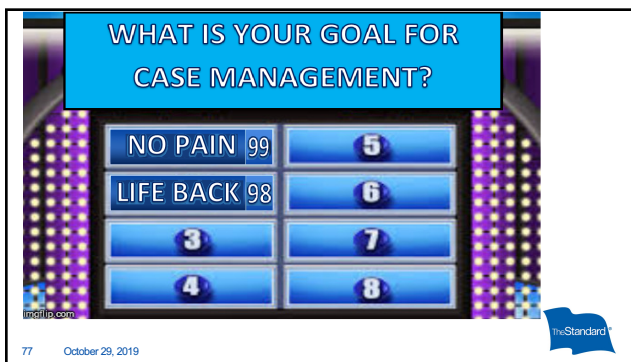
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### “What is your goal for case management?”

To use if licensing issues are raised.

- “No more pain” – This is probably the most common answer for people on opioid pain medication.
- “I just want to get my life back” – This is also extremely common among people on opioid pain medication.
- “I want to get off these drugs” – This isn’t common at all, but if you hear it, consider referring the person to an appropriate addiction treatment provider.

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### If someone does say they want to get off their opioid pain medications...

Consider referring them to an addiction treatment specialist.

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### Be Sure to Assess for Behavioral Health Conditions

People on long-term opioid medication are at elevated risk for:

- Substance Use Disorders
- Depression
- Sleep Disorders

If your assessment is positive for any of these, consider a referral to an appropriate specialist.

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### Risk Factors for Chronic Pain

- Smoking
- Alcohol use
- Obesity
- Limited physical exercise
- Poor sleep
- Poor nutrition

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### And remember the vicious circles from before

- Sleep
- Mood
- Physical Activity
- Nutrition
- Thinking

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### Tracking Pain

It's important to track the person's level of pain so they can understand that it varies over time and that specific thing may impact it.

Date	Pain Rating
06/01/19	4
06/02/19	3
06/03/19	4
06/04/19	5
06/05/19	4
06/06/19	2
06/07/19	3
06/08/19	3
06/09/19	4
06/10/19	5
06/11/19	2
06/12/19	3
06/13/19	4
06/14/19	2

Most people track pain as a single number, using a question like, "Please rate your pain today on a scale from 0 to 10, where 0 is no pain at all and 10 is the worst pain you could possibly imagine."

It's helpful to graph this information so the person can see trends they wouldn't otherwise notice, especially if their pain is slowly decreasing over time (which is common).

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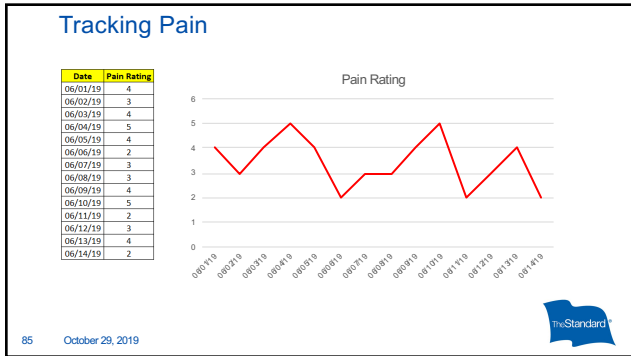
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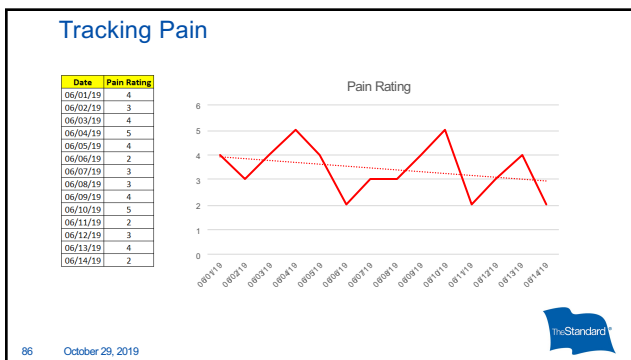
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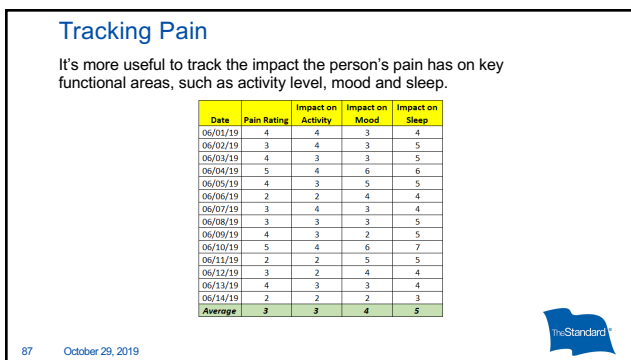
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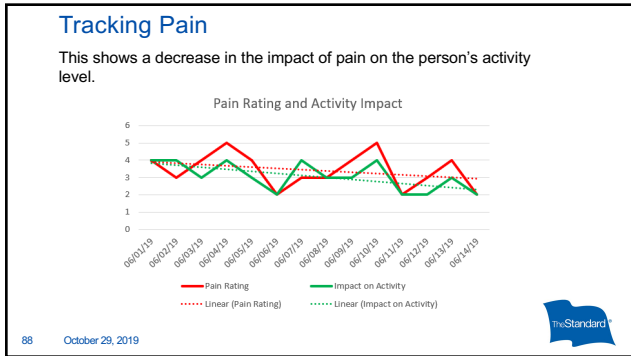
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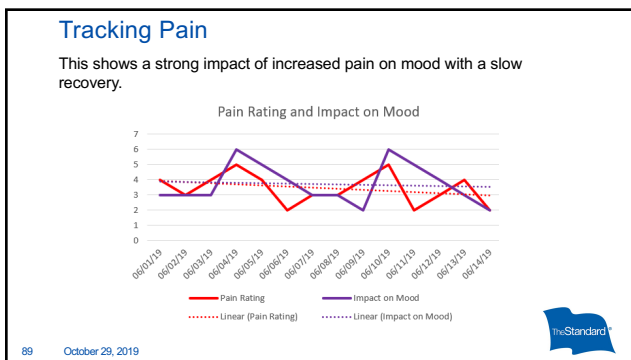
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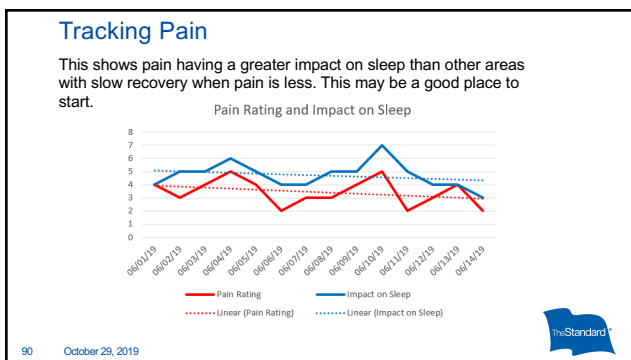
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### Self-Management of Chronic Pain

Treatment of chronic pain may be most successful when the person suffering from the pain becomes an active participant in the treatment.

- The person feeling the pain is the biggest expert on it.
- They can determine what approaches are most suitable for them, set the pace of treatment, identify barriers and select solutions, and balance different tactics to facilitate the best possible outcomes.
- They are in the best position to determine whether an approach is working or not.

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### Self-Management of Chronic Pain

There are several prerequisites to successful self-management of pain, however:

- The person cannot be a passive recipient of treatment, they must be willing and able to take an active part in their therapy.
- They must be willing to communicate directly with their treating providers, including asking questions and challenging approaches that they are not comfortable with.
- They must be willing to learn about their condition and about possible treatments.
- They must be willing to question their established thoughts and feelings about their condition.

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### Some Other Useful Approaches

- Focus on physical functioning and encourage a long-term view of their activity level, abilities and life satisfaction
- Encourage movement and, to the extent approved by the treating physician, exercise
- Support social activities and social support
- Consider teaching abdominal breathing or mindfulness

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Pain is all in your head, but that doesn't mean it isn't real!

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Questions?



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Note: Some sites require a subscription to access.

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### Working with the People on Opioid Medications

- I'm no ergonomist, so I relied on the Ergo-Plus Web site for information on basic ergonomic principles to minimize pain; see <https://ergo-plus.com/fundamental-ergonomic-principles/>.
- I'm also no Occupational Therapist, so I got information on those approaches from the American Occupational Therapy Association (AOTA) Web site at <https://www.aota.org/About-Occupational-Therapy/Professionals/HWPain%20Rehabilitation.aspx>.
- Concrete suggestions for talking with people with chronic pain are given in the Oregon Pain Management Commission (OPMC) training presentation at <http://www.oregonpainmodule.org/req/opp/menu.aspx>.
- Information about self-management of chronic pain can be found at <https://medlineplus.gov/magazine/issues/spring11/articles/spring11qa5-6.html>.



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## References

### Working with the People on Opioid Medications

- "The pain is all in your head..." See <https://www.psychologytoday.com/us/blog/day-without-pain/201301/chronic-pain-it-is-all-in-your-head-and-it-is-real>.
- You might also be interested in my blog post, "The Opioid Epidemic: How to Address Drug Use in the Workplace" at <https://www.standard.com/employer/workplace-possibilities-program/opioid-epidemic-how-address-drug-use-workplace>.
- The National Safety Council has a comprehensive toolkit for employers who want to address opioid misuse at work, located at <https://www.nsc.org/pages/prescription-drug-employer-kit>.



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