Review Article

Opiate Addiction and Prescription Drug Abuse: A Pragmatic Approach

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Abstract

In the United States, the abuse of prescription medications, and especially opiates, has significantly impacted escalating health-care costs, increased patient hospitalizations, and has led to a growing number of untimely deaths. Approximately 14% of American adults are using pain medications for nonmedical purposes; therefore, the recreational use of opioids is steadily on the rise. Contributing to the problem is a small number of physicians who indiscriminately prescribe opiates without proper assessment and a lack of use of nonaddictive adjunctive medications. The result has created a culture of iatrogenic drug addiction, and the offending providers are described as being "legalized drug pushers." There are several pragmatic changes to physician practices that are proposed that address this ever-growing problem. This includes limiting narcotic prescriptions for noncancer pain management. In addition, physicians must monitor the dosage, quantity, and treatment duration of narcotic usage. In the treatment of opioid dependence, physicians must properly control the use of agonist replacement treatments as these have developed a street value. Without adequate support measures and follow-up, the prescribing of narcotics will have addictive consequences. Additionally, certain treatment guidelines are recommended. These include restricting the patient to one pharmacy of his or her choice, expecting the patient to attend regular treatment support groups, requiring the patient to pay copayments in advance and other measures. These, along with changes in public policy and educational programs, will limit the growing trend of prescription drug abuse in the United States.

Key words: Prescription drug abuse, pain management, addiction, health policy.

Impact and Statistics

A decade into the 21st century, the United States is in the midst of a major public health problem. The abuse of prescription drugs, especially opiates, is at near-epidemic proportions and has significantly contributed to escalating care costs, increasing patient hospitalizations, and a growing number of untimely deaths. An estimated 14% of American adults are using pain medications for nonmedical purposes, and the recreational use of opiates has steadily risen during the past decade. From 2002 to 2006, the percentage of young adults from the age of 18 to 25 abusing prescription opiates jumped from 4.1% to 4.6%. These figures suggest that approximately 1.5 million young adults are readily abusing these medications.[1] Additionally, opiate-related emergency room visits increased 126% from 2004 to 2008. Treatment admissions for nonheroin opioid

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abuse and dependence are also on the rise. From 1996 to 2006, the number of these treatments nearly quadrupled nationally from 16,605 to 74,750. In West Virginia, this trend has been especially severe.[2,3] During the same 10-year period, nonheroin opioid treatment soared in this state from two treatments per 100,000 to 78 per 100,000. Currently, West Virginia has the third largest nonheroin opioid abuse rate in the nation.

Although tobacco, alcohol, and marijuana previously have represented the drugs of choice for adolescents, recreational use of pharmaceuticals has the potential to become as prevalent. This is due to the relatively low cost, ready availability, and accepted medical use of prescription medications. In addition, the problem is enhanced by a small percentage of unscrupulous providers, who for financial reasons, play a major role in this epidemic. It is our opinion that pain assessment, psychosocial history, and patient behavior are not adequately assessed before opiates are prescribed.

A culture of iatrogenic drug addiction and legalized drug prescriptions have been created. The offending providers are described as being "legalized drug pushers." The lack of standardized pain assessment instruments and protocols seems to be common. Psychosocial and behavioral techniques as well as nonaddictive adjunctive medication as alternatives to opioid prescriptions are not adequately explored.

Pain Management

Narcotics use for noncancer pain should be time-limited and used as a last resort, not as a first line of treatment. Before the institution of pain management, a full assessment of pain should be performed, and nonnarcotic medication with psychosocial intervention should be tried initially before narcotics are used.

Even when legitimately used, narcotic prescriptions should include dosage, quantity, and treatment duration that is adequate to treat the pain. Monitoring the use of these medications reduces the risk of patient abuse and dependence, and decreases the likelihood of diversion through the drug's sale or theft.

Because diverted prescription pain medications are the leading source of opioid access for adolescents, the importance of limiting quantities of prescribed narcotics cannot be overstated.[4]

Opioid Treatment Dependence

Although methadone and Levaquin-acetylmethadol (LAAM) have been used as agonist replacement treatments for opioid dependence, the Substance Abuse and Mental Health Services Administration is now recommending buprenorphine (Subutex) and Suboxone, a combination of buprenorphine and naloxone, as office-based treatment alternatives for opioid addictions.[5] Physicians can be licensed to prescribe buprenorphine with minimal training and are required to refer patients only for adjunctive psychosocial treatments. Unfortunately, buprenorphine has developed a street value.

While using Suboxone to treat opiate addicts has been successful, the length of treatment and dosage are still being debated. We believe that the proper prescribing of newer agents will prevent these drugs from achieving the same fate and notoriety as methadone.

Motivation

Another factor that plays an important role in the prognosis and treatment of drug addiction is motivation. Assessing an individual's desire is subjective, hence problematic. Although psychosocial tools exist, consequences or losses associated with drug use and abuse are more accurate predictors of a patient's motivation. These consequences include being ostracized by social and/or religious groups; personal and professional losses in the form of income, jobs, professional licensures, and intimate relationships. As society becomes more tolerant of these issues, drug addiction and abuse become more pronounced. Often the patient's family and friends become tolerant of this behavior over time and enable the addiction.

Recommended Treatment Guidelines

While general guidelines for drug abuse treatment should be observed, we recommend the following:

a. Detoxification is not a cure for opiate addiction or any addiction for that matter.

b. Restricting the patient to one pharmacy of his or her choice throughout the treatment.

c. Requiring the patient to attend regular

Narcotics Anonymous (NA), Alcoholics Anonymous (AA), or other treatment supportive groups. It is recommended that the patient with an addiction attend these sessions three times a week for the first three to four months and that their attendance is documented in a log and signed by their sponsors. The frequency of these sessions could be gradually reduced.

d. Obligating the patient to pay copayments to ensure compliance. Third parties can assist by keeping the copayments as low as possible ($10 to $20 per session). In addition, we recommend that Medicaid patients pay a small copayment ranging from $5 to $10 as a demonstration of the clients' commitment to treatment. If patients fail to attend designated treatment and counseling sessions, prescriptions should be withheld until the patients return to counseling sessions.

e. Reporting to the appropriate state agencies any excessive charges by physicians and counselors.

f. Using standardized tests such as pain assessment tools as a minimum requirement for opiate drug therapy is absolutely necessary. Documenting the use of adjunctive treatment modalities remains important.

g. Administering goal-directed therapy with gradual tapering of medication as patients progress through treatment.

h. Licensure renewal may be tied to the successful completion of training. For example, some states, such as California, require pain-management certification as part of licensure and maintenance of licensure.

i. Monitoring and documenting objective factors in detoxification include blood pressure, pulse, respirations, diarrhea, rhinorrhea, and lacrimation. Both subjective and objective symptoms should be used and individualized for treatment.

j. Collaborating between physicians and addiction specialists is critical.

k. Limiting the Suboxone treatment dosage, in most cases, to not exceed 16 mg per day. This treatment should also be time-limited with gradual tapering ranging from six months to two years, depending on the patient's needs. It should be supplemented with a biopsychosocial approach (attendance at NA/AA and counseling sessions) and performed by professionals trained in addiction medicine (psychiatrists, American Society of Addiction Medicine [ASAM]-certified physicians or physicians undergoing special periodic addiction training).

Another concept that needs to be explored is the opening of a methadone detoxification clinic to be run by nonprofit agencies with the stipulation of getting motivated patients off methadone instead of the trend of keeping patients on methadone indefinitely, as practiced currently by some for-profit agencies. A small percentage of patients on methadone who are undergoing severe emotional, financial, and behavioral problems and fail other treatments may need to be on methadone longer. Physicians should be aware that if they are not able to provide such treatment, they can and should refer some patients to methadone maintenance clinics.[6]

While the above-mentioned treatment recommendations represent a practical approach employed by physicians, these are only part of the equation. We believe that these steps alone are insufficient, and additional action at the public policy level is needed. These include the following:

Public Policy Recommendations

First, the Drug Enforcement Agency's (DEA's) regulation for Schedule II drugs with a high likelihood for abuse needs to be seriously evaluated. Such drug dispensing should be restricted and time-limited. In addition, triple prescription copies are warranted. One copy should be kept on file with the prescribing physician, one with the dispensing pharmacist, and one submitted to the DEA in that geographic area in order to review and verify that drugs are being dispensed properly.

Second, medical boards should be authorized to conduct periodic audits of patients' charts and other physician records for compliance with good clinical practice guidelines. This is especially critical with regard to cases where physicians are prescribing a large amount of narcotics. Changes in laws may be needed to address that scenario.

Third, increased public awareness and an opiate education program addressing inherent dangers need to be promoted at the national and local levels via the media. Patients must be educated on the proper disposal of leftover portions of opioid prescriptions. This will contribute to a decrease in the amount of diverted pain medications sold on the street.

Fourth, there should be a great enforcement of

providers accepting private or government insurance (Medicaid and Medicare). Physicians engaged in abusive charges in exchange for prescribing narcotics need to be reported to state professional boards and licensure agencies. Conversely, authorities should investigate patients who "doctor shop" or "pharmacy shop," and appropriate charges should be filed against the patient.

Finally, controlled prospective studies need to be conducted to determine treatment effectiveness of Suboxone across multiple social and economic domains. Post-treatment follow-up needs to be conducted through interviews and random drug testing for an additional year. Success would be determined upon the patient's ability to resume, maintain, and fulfill social and life-related obligations. These results would be verified by additional means such as random drug testing.

While prescription drug abuse exists in epidemic proportions, it has the potential to spiral out of control to conditions not yet seen in modern society.[5,6] The implementation of more stringent guidelines and broad-reaching educational programs are imperative to stop the potentially dangerous trend.

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