

AMA Advocacy Insights webinar series: Drug overdose epidemic

Featured topic and speakers

The nation's drug overdose epidemic—Helping children and families, patients with pain

Most descriptions of the nation's worsening drug-related overdose epidemic highlight the more than 100,000 individuals who have died in the past year.

Broad solutions supported by the AMA and many others point to the need to remove all barriers to medications to treat opioid use disorder, enforce mental health and substance use disorder parity laws, and greatly increase access to harm reduction efforts such as fentanyl test strips and naloxone. Within the tragic mortality figures, however, are unique effects of the epidemic on children and adolescents, historically marginalized and minoritized individuals, and patients with pain.

This AMA Advocacy Insights webinar looks closely at each of these areas from the perspectives of physicians who provide care to these patient populations.

Meeting documents

- Webinar slides from Dr. Agarwal (PDF)
- Webinar slides from Dr. Chapman (PDF)
- Webinar slides from Dr. Sedney (PDF)

Speakers

- Rita Agarwal, MD, clinical professor, anesthesiology, Stanford University, School of Medicine and past president, Society for Pediatric Pain Medicine
- Edwin C. Chapman, MD, founding member and secretary of the board of directors, Leadership Council for Healthy Communities
- Cara Sedney, MD, MA, associate professor and residency program director, Department of Neurosurgery, West Virginia University

Moderator

- Bobby Mukkamala, MD, chair, AMA Board of Trustees

Transcript

April 5, 2022

Dr. Mukkamala: Good afternoon, everyone. I'm Dr. Bobby Mukkamala, chair of the AMA Board of Trustees and chair of the AMA Substance Use & Pain Care Task Force. Hello and thank you for the opportunity to join you today for this important conversation. And more importantly, thank you for being a part of it. COVID-19 has understandably consumed our attention for the past two years.

The AMA has, since the beginning, urged that public policy responses be focused on the best available medical evidence and time-tested public health principles. Today, we're going to talk about medical evidence and public health approaches to a different epidemic, the nation's drug overdose epidemic. One that has been with us and has worsened since COVID began. In fact, in a 12-month period from 2020 to 2021, overdose deaths exceeded 100,000 for the first time ever.

No community or demographic is untouched and tragically it is killing more and more young people. Those aged 15 to 24 experienced the largest percentage increase in drug overdose deaths between 2019 and 2020, nearly 50%. A shocking, troubling and hopefully motivating statistic. I think back to my own social media feed over the past two years and it was a steady stream of stories of loss from COVID but inevitably mixed among those losses were the struggles, losses and pleas for help for the families of young ones struggling with substance use disorder.

I sometimes will step out of my routine and change things up a bit just to see what other aspects of life in my hometown of Flint, Michigan, are like. On one such day, I decided to ride our MTA, our city bus. I witnessed several young adults riding the bus and overheard the conversation. It was about their inability to drive because they had lost their driver's licenses. They were headed to a meeting for their court-mandated treatment for substance use disorder.

Interestingly, they didn't seem angry or bitter. They seemed to acknowledge that the day's activities existed to help them but I couldn't help but think of the thousands of others, the hundreds of thousands of others, that we have lost that never got the opportunity to be on that bus. What makes this phase of the overdose epidemic different than a few years ago is that the epidemic is now being fueled by a dramatic increase in the use of illicit fentanyl and fentanyl analogs, as well as methamphetamine and cocaine, rather than prescription opioids.

We must also look closely at our own practices to ensure that we address any health inequities that might negatively affect our black and brown patient. For example, the overwhelming majority of patients who receive buprenorphine for opioid use disorder are white. The overwhelming majority of patients who receive methadone, however, are Black. This data needs assessment and work to ensure that all of us have access to the best care for our needs.

Many of you will recall that back in 2014 and 2015 as greater numbers of Americans were dying of drug-related overdose, policymakers began to increasingly point the finger at opioid analgesics. The data show in 2014 and 2015 that tens of thousands of Americans were dying of opioid-related overdose but even then, it wasn't just prescription opioid analgesics. Yet, the policy approaches focused almost entirely on how to restrict opioid prescribing. This includes the inappropriate 2016 CDC opioid prescribing guideline, that has been so widely misapplied, that thankfully the CDC now recommends removing all dose and daily quantity thresholds.

The effects of the narrow focus on opioid analgesics increase the stigma on patients with pain, to such a degree that it is common and a false perception that a single opioid prescription would lead to inevitable dependence and death. That stigma has harmed hundreds of thousands of individuals. We know about the many patients with cancer or in hospice being denied pain care. We know about patients with chronic pain being told to tough it out. But we haven't thought of how the fear and stigma that has surrounded a legitimate form of pain care has affected children. And we haven't accepted the fact that nearly two-thirds of people who say they misuse opioid analgesics do so to self-treat their pain.

One of the most common procedures kids undergo is tonsillectomy and adenoidectomy. I have the dubious honor of putting kids through this every week. Our own management of postoperative pain in these kids has changed in the past decade. What used to be a routine prescription for 10 days of acetaminophen with codeine has now changed to mostly plain acetaminophen and ibuprofen but I maintain the ability to assess each patient's experience with their pain.

It's not an arbitrary, formulaic decision. How I treat my almost adult 17-year-old patient is different from how I treat my 10-year-old patient. I assess and come up with that individual plan. Unfortunately, the misapplication of the CDC guideline obstructs much of my ability to assess and treat. And more importantly, it leads to preventable suffering of my patients. Earlier this year, the AMA and the national experts at Manatt Health issued a toolkit that builds on our previous work and identifies actions that

should be taken immediately to prevent more loss of life.

First, we call on policymakers and other stakeholders, including health insurers, pharmacy benefit managers and national pharmacy chains to remove barriers to evidence-based treatment for patients with a substance use disorder. It means removing prior authorization and utilization management policies for medications to treat opioid use disorder and other evidence-based approaches. It means addressing disparities and the needs of all patients equitably.

Next, policymakers must enforce mental health and substance use disorder parity laws. The Mental Health Parity and Addiction Equity Act that was enacted more than a decade ago on a simple principle, mental health and substance use disorder services should be covered just like broken bones and blocked arteries. If coverage for these conditions is not as comprehensive or it's more restrictive, that's a parity violation. Insurance companies continue to violate this law to actively discriminate against patients with mental illness or a substance use disorder.

Next, we must improve access to multidisciplinary, multimodal care for patients with pain. This means ensuring a broad range of affordable and accessible pain treatment options, both pharmacological and non-pharmacological without barriers. And we call on the CDC to finalize its clinical practice guideline for prescribing opioids for chronic pain this year.

And finally, we must expand harm reduction efforts. This means making Naloxone available without a prescription and prohibiting life insurance companies from taking adverse action against those who have obtained Naloxone. It means removing drug checking supplies such as fentanyl test strips, from drug paraphernalia laws so there isn't a penalty for trying not to die. It means that we meet people who use drugs where they are, do all we can to support them staying alive so that when they are ready for treatment, they will trust us and take that important step.

With us today to discuss these approaches are three experts, three physicians who encounter patients struggling with substance use and mental health challenges every day. Dr. Rita Agarwal, a clinical professor of anesthesiology at Stanford University of Medicine and past president of the Society for Pediatric Pain Medicine. Dr. Edwin C. Chapman, founding member and secretary of the Board of Directors of the Leadership Council for Healthy Communities. And Dr. Cara Sedney, who is an associate professor and residency program director at the department of neurosurgery at West Virginia University.

We thank each of you for the work you do and the lives you are saving in spite of the barriers you face on a daily basis some of which I just described. I will ask each of you to speak for five minutes and then we'll move to a moderated discussion. Dr. Agarwal let's start with you.

Dr. Agarwal: Hello. It's still morning for me. I am on the West Coast. I have no financial disclosures. As Dr. Mukkamala mentioned, I am the past president and actually founding member of Society for

Pediatric Pain Medicine. Also, the past chair of the AAP Section on Anesthesiology and Pain Medicine.

So, I'm going to talk really about pain specifically and not so much about substance use and misuse. We know that there are consequences for untreated pain that include things like prolonged stress response, reduced immune competence, respiratory dysfunction, increased incidence of chronic post-surgical pain syndromes, and on and on. A lot of different things. Unrelieved pain is not a good thing and we do need to treat it.

So, the most common thing, of course, that we use to treat it is opioids. And why do we use opioids? Because they work. And currently there really just is not anything that is as flexible, as effective and available in as many different modalities and routes as opioids. So, these do continue to be the mainstay of treatment for pain management. We've heard a lot of talk about multimodal analgesics. And honestly, back when I first started 30 years ago, we didn't use these fancy terms. We just tried to treat pain from a lot of different approaches using different kinds of medications to decrease the amount of opioids that we needed to give in order to get effective pain management.

What we really need to focus on though more and this is where insurance companies can often be a barrier, is multimodal analgesia and not so much analgesics. And that's trying to use a combination of approaches to improve and get to functional recovery, as opposed to just treating a number, a pain score. These include things like the analgesic agents that we use, adjuvants and complementary approaches to medicine, mental health care and physical medicine and rehab.

These are all really incredibly important approaches and often these areas that we struggle to get the kinds of support that we need. Some of the non-opioid approaches to pain management include, again, the use of nonsteroidals COX 2 inhibitors, acetaminophen. Clonidine is an excellent drug. It's an adjuvant drug. It doesn't work that well by itself, but it can really help improve pain, both in the acute and the chronic setting.

Gabapentinoids, ketamine, lidocaine, local anesthetics. In kids, particularly improve and particularly important and effective are things like distraction, virtual reality, storytelling, blowing bubbles, video games, biofeedback, self-hypnosis and deep breathing. Kids are very responsive a lot of times to these kinds of approaches and often it does take experts in pain psychology and other fields to really help get these across to them well.

A couple of words about some of the adjuvant medications. Ketamine in particular has become a really popular part of the multimodal or opioid-sparing or opioid-free approach to pain medication. I just offer some caution. It's an excellent analgesic, no question. It's also a dissociative anesthetic and has its own side effects, including hallucinations and this feeling of being out of your body. It can be administered by multiple routes so it's useful in that sense. If you don't have an IV, you can take it orally, intranasally. There's lots of different ways it can be given.

It can be given as bolus doses or continuous infusions but it is also a common drug of misuse and so should really be used cautiously in patients. The other commonly used class of drugs are the gabapentinoids—gabapentin or pregabalin—that are increasingly used to try and decrease or prevent the use of opioids for acute pain management. These are anticonvulsants. They have been used in multiple different situations and scenarios. There's a lot of question more and more recently about their efficacy and the duration of time that we should be using these for.

I'm an anesthesiologist and a pain specialist so a lot of my work and a lot of my interest is around the perioperative period. Increasingly, the studies are not showing there as effective as we had hoped, but they still are commonly used. And unfortunately, again, these are drugs that can be misused and so should be used cautiously. So going back to opioids, because again, these are still the most commonly used medications, particularly in the perioperative period for postoperative pain management, as well as for many other acute settings.

There is a big mismatch that continues to be a big mismatch between what is prescribed and what is needed. And this is, I think, where a lot of work is being done; the University of Michigan, in particular, should really be applauded for a lot of the work they're doing. This particular study is out of Tennessee where they had fairly restrictive opioid prescription laws. And this was for pediatric patients undergoing ambulatory surgery; so outpatient surgery, minor surgery. Mean age was nine and that's the dose range.

The thing that's important here is that the median doses prescribed of a postoperative opioid of some kind was 12.9. Sorry, there's a typo there. It should be 12.9 with a range of nine to 20 doses. And doses included either a tab or a liquid. The median doses consumed, however, was two. So that is a huge mismatch. And this is a 2022 study. This is recent. 90% of patients or families had leftover opioids and only 42% of them disposed of the leftovers, which is actually a huge increase from earlier studies from the late 2000 teens, 2016, '17 where only 5% were actually disposing of leftovers.

This is a study from Dr. Monitto and her colleagues from John Hopkins looking at, these were patients having more major surgery done. These were patients that were admitted to the hospital for a period of time and then discharged with opioids. And again, this continues to show a mismatch. The gray shows, I don't think I can highlight this but the gray bars show the doses dispensed. The white boxes show the doses consumed. PSF is posterior spinal fusion. Pectus is pectus excavatum. Ortho included other major orthopedic surgery and on down, cardiac surgery, neurosurgery, et cetera.

And so, you can see that there continues to be a mismatch with the amount of opioid dispensed and prescribed, and the amount of opioid actually consumed. This is important, but so is the next slide, which shows the number of patients who continue to need an opioid a certain amount of days post-surgery. Zero days, 30 patients out of this group didn't require any opioids but look at greater than 10 days. There is still a significant number of children who are requiring opioids.

And so, this really goes to the fact that one-size-fits-all laws don't work and shouldn't be enforced. Primarily, the red represents orthopedic surgery and it's not surprising to anyone who's ever had orthopedic surgery that 10 days out from surgery you can often still have significant pain. Purple is general surgery and that's the next most common group. And then the blue is plastic surgery. And these are major plastic surgeries, not minor, more reconstructive type surgery.

So again, one size fits all doesn't work. Restrictive laws don't work. Some children will require more pain medications after surgery and some children won't require any. Why does it matter? It matters because this very terrifying, I think, study from 2020 in JAMA shows that in youth or young adults who had an opioid prescribed either to themselves or their family member, the risk of opioid overdose was significantly greater. And this is really concerning.

It's concerning to me as a pain physician who prescribes a lot of opioids and it should be concerning to all of us that we don't really have a good handle on this. And I'm hoping our other two speakers can address how we can match patients with what their needs are a little bit better. These are some of the things that have been done. This is just a poster that was made by the American Academy of Pediatrics. I know that the American Medical Association, CDC, many other organizations have their own versions of approaches to discussing with the families and with the patients, safe opioid use and disposal.

So I'm going to just stop by saying that children do deserve excellent pain management. Currently, our number one tool is still often opioids but we should be looking more and more at providing multimodal analgesia and trying to get our insurance companies and get the resources to help really address all the different aspects of pain management.

Consider local anesthesia or regional anesthesia or topical local anesthetics, wherever that may be appropriate and may work. And we need to really be looking critically at how we decrease that mismatch between prescription and need for pain medications. And how, in particular, we address patients at risk and help support families in whom this may be more of a concern. Thank you.

Dr. Mukkamala: And you can see already in the chat, there have been some requests for slides. And so yes, those slides will become available in a day or two afterwards. Next, Dr. Chapman, please share your experiences with us.

Dr. Chapman: So, I want to really show that we've frequently talked about the opioid epidemic having been in three phases. We can see, we talked a lot about opioid pain medicine and then the transition between the year 2000 and 2019 to heroin. And the third phase are the synthetics. When we look at the African American experience, we have to look back to the Vietnam era. And in the African American community, drug use with opioids was primarily with street drugs and starting with heroin, and then transitioned to fentanyl. So, there were only two stages.

So, pain is a common denominator and we have to look at pain not only as just physical but also psychic pain or post-traumatic stress disorder or toxic stress. So, when we look at Black and Brown communities, we have to talk about oppression and racism through the years. So, the white epidemic, this predominantly talked about pain medication, the Black epidemic primarily racism, PTSD and self-medication with street drugs.

So we really want to look at all of the components: the psychic component, the physical component and the environmental component. And this gives us what one might call the addiction index. Now we know from these two Princeton economists that the opioid epidemic also is impacted by economics. And we talk about diseases of disparity and particularly in communities where the economy has changed dramatically.

And this is a study from JAMA Internal Medicine and they looked at the closure of automobile assembly plants. And you can see that after five years there was a marked increase in opioid use and probably alcohol use in those communities. And there was no difference between pills or street drugs. So, we're really talking about the emotional component. And we can see that this particularly impacted after five years, there was an 85% increase in mortality. And that mortality impacted primarily white men between the ages of 18 and 34, as well as 35 and 65.

So, in the African American community, even pre-COVID between the years 2018 and 2019, we saw a leveling off of the opioid overdoses in the white community but we saw a 40% increase in the African American community. And, of course, this is due to the fact that African Americans moved from heroin to fentanyl. And here in Washington, D.C., we went from 20% fentanyl in 2015 to 95% fentanyl in 2020 and 2021. So, you can see this dramatic increase in non-Hispanic, Black men particularly in the past five years.

So when we really look at this composite, we really have to talk about toxic stress as Dr. Gabor Mate pointed out and the impact on the neurological and psychological systems. And, of course, early adversity and stress mistreatment, and particularly childhood abuse and increasing susceptibility to addiction. So, all of these really convert into what we call the pair bases or adverse childhood experiences and adverse community environments.

And we can see these outcomes in our communities with neonatal abstinence syndrome. And, of course, and a marked increase in foster care as a result of parents and grandparents, who were taking care of children, actually overdose and die. So, at the root, we can see discrimination, community disruption, including gentrification, lack of opportunity, unemployment, poor housing quality really creates those adverse childhood experiences with maternal depression, emotional and sexual abuse, substance abuse, homelessness, incarceration. All of these are the leaves on the tree.

And of course, the opioid crisis has exacerbated all of this. So when we look at this and we talk about the cycle of despair, we can see that the entire community is involved; the entire village. So we have

faith community stigma, medical provider, rejection, family and community ostracism, government apathy and lack of insurance, inequitable access to pharmaceutical treatment and incentivized prison industrial complex where particularly Black and Brown patients were incarcerated for years rather than treatment.

So we want to look now at the cycle of repair. What do we do post-incarceration? What do we do post-overdose? What do we do with homeless people, who are disproportionately impacted by mental illness and substance abuse, in terms of treatment and of course, self-referrals? So we want to take a village approach and that village approach, of course, involves medical treatment and reconciliation at the core but we also need advocacy and legal surveillance. We need community support and education from the faith community, food, clothing, transportation, and of course, employment support.

And when we look at an example like Cecil County, Maryland, where the automobile assembly plant closed years ago; we can see the perfect example. And they took a proactive approach, realizing that after noting that there were so many children who were in foster care because their parents had died, that they needed to address emotional trauma in children. So they built this around actually five pillars: enforcement, treatment, recovery, prevention and the community support services that we talked about. They got a grant from the federal government and really work around that in terms of really bringing children into trauma treatment for their emotional distress.

And finally, we have to address, as Dr. Mukkamala pointed out, stigma. And stigma crosses the medical community. It crosses the pharmaceuticals and drug stores but it also impacts patients. And so, we have three prongs where we have difficulty in actually getting cooperation. And this is a recent study that shows that contingency management—actually using cash payments to patients—has a three times better outcome than cognitive behavioral therapy alone.

So contingency management is being studied using cash payments to patients. This sounds somewhat counterintuitive but the studies are very promising. And these are some of the outcomes with just patients who are suffering from stimulant addiction that with \$600 compared to the cost of \$570 of an emergency room visit or \$1,200 for an ambulance ride or \$1,300 for imprisonment that we can actually impact these outcomes by stimulating patients to participate in treatment. And I'm going to stop there.

Dr. Mukkamala: Thank you, Dr. Chapman. There was a stark reminder when you put up the slide with the plant closures in Flint, Michigan. Those plants have been closing over the course of the past 40 years. And you saw the numbers as far as the young folks in the community that are also at risk of substance use disorder. And I can't help but think there's a multi-generational impact of those sorts of closures. Thank you. Dr. Sedney, the screen is yours.

Dr. Sedney: Thanks. Thanks so much for having me on the panel. Just as a brief disclosure, the NIH funded by opioid work that I'm going to talk about. So as most people know, West Virginia has been

really hit hard in the opioid crisis. And one of the things that was implemented here as in many other states was a restrictive opioid prescribing law. And as a surgeon, I was initially worried about how this law was going to affect my postop patients and their access to opioids. You can imagine having a surgery like what you can see on the X-ray, that would definitely need opioid medication postop.

So in order to study the effect of this law, which was my initial interest, our research team created a sequential mixed method study using an ITS analysis of state PDMP prescription data to understand how the actual prescriptions changed at law implementation. And then we interviewed stakeholders such as prescribers, dispensers and patients, and we included people who used diverted or illicit substances in those interviews. And what we learned in studying this was applicable more broadly to the opioid crisis, so I'm going to talk a little bit about that.

So to just briefly explain the methodology of this research, the ARIMA interrupted time series analysis is pretty complex but it's also a standard way to understand the effect of law in the real world, including drug laws. And you need a lot of data points to do this because, you end up constructing an equation out of the data that you have and include a bunch of variables for things like auto correlation and seasonality. And then you're able to actually predict how the numbers will change in the future.

And then you add in another variable, like a law implementation associated with a specific date and you can demonstrate that additional variable changed the data or not. And so that helps us understand kind of how prescribing changed as a result of this opioid prescribing law in West Virginia. But then the qualitative investigation helps us put that into context. And the qualitative research is really what's exciting here, in my opinion, because without the context, the numbers aren't that helpful.

So these are the ITS results. First, I'll direct your attention to the top right, which is the main focus of the law, which was day supply of medication. The law limited first-time opioid prescriptions to anywhere from three to seven days depending on who was prescribing, ER or surgeon or whatever. But interestingly, the law did not change that at all, not one bit. Then I'll direct you to the bottom left. The law mandated that the lowest effective dose of medication be used, which is very general but we looked at daily MME and ironically there was an increase in the daily MME initially, but then a small downward trend.

But overall, the change as a result of the law, was only a 1.1% change in the daily MME, so basically no change. And then I'll direct you to the bottom right, the new opioid prescriptions. There was again no change here, which is really interesting, because the law really focused mainly on new prescriptions but there was in the top left corner a significant change in the overall opioid prescriptions. Meaning that the chronic opioid prescriptions were more significantly affected.

And this was really interesting because there was actually very few limitations on chronic opioids written into this law. They had to get refilled every 30 days and that was about it. And people on opioids prior to the law signing were actually exempt. So, it didn't even apply if you were on opioids

before January 2018; the law was signed in March 2018. So, something else was going on here and I'll point out, too, that we did a benzodiazepine control to confirm all these things.

And this is where our qualitative analysis and stakeholder interviews come in and our stakeholders really brought this data to life. A predominant theme we saw in many of the physician interviews was fear that impacted their prescribing behavior, specifically fear of disciplinary action because of opioid prescribing. The physicians noted that this fear was actually present before law implementation. And they gave examples of physicians in their own communities who were investigated, even ones that they perceived have been practicing appropriately, who essentially had their practices ruined due to ongoing investigations even if they were never found to have done anything wrong. And this was all before the law, in many cases, so part of a broader pattern.

And then not surprisingly, there ended up being care shifts as a result of this change. Particularly after the law enactment when people sort of said, "This is the last straw. I'm not prescribing anything." They wouldn't even prescribe gabapentin. And so, at this time, patients were essentially abandoned after prescribers stopped prescribing opioids and they flooded to other prescribers who were then left to shoulder their responsibility and possible liability of caring for these people. Although often the local care infrastructure just wasn't able to handle that influx.

So, the general question amongst the prescribers that we interviewed was, "Where did they all go when they left my office?" And the physician's hypothesis to that question was that a large segment of these patients transitioned to illicit substances and our patient interviewees actually verified this. They said that their transition to illicit substances was to self-treat pain or physiologic withdrawal or both. And interestingly, we tried to interview chronic pain patients and patients who used drugs as two separate groups, but there was a ton of overlap.

Nearly all of the patients we interviewed who use illicit substances had started with chronic pain and many of our participants noted that the care gap where they were unable to continue their opioids resulted in a progression to what was essentially a mild opioid use disorder, just having physiologic dependence to a severe opioid use disorder. So I think this really brings together the talks of Dr. Agarwal and Dr. Chapman. And I think it emphasizes, the research emphasizes the detrimental effect of opioid restriction measures on patients with chronic pain.

And I think it emphasizes the need for fail-safes to prevent patient abandonment were non-chronic opioids. And moving forward I hope we can see patients on chronic pain medications as sort of a more vulnerable group, which I think that they are. And I wholeheartedly agree with everything all the initiatives mentioned earlier and I'd be happy to further discuss.

Dr. Mukkamala: Thank you very much, Cara, for the very informative conversation so far. So, we've got a bunch of questions. We've got probably about just under 20 minutes to get to those. So, I'm just going to kick it off with one of them. "If studies indicate a 44% reduction of opioid prescriptions over

the decade but that's coupled with a 30% increase in opioid overdose deaths, what's the best way to deal with illicit drugs?"

I can give the AMA answer and that's to treat more, treat for of substance use disorder pain, increased access to harm reduction enforcement of parity. I mean, that's how we deal with people that have a substance use disorder for illicit drugs. I'm a bit interested to hear what you would say to somebody that says, "Look, we're prescribing less but there's increased risk of opioid deaths. What are the solutions for that?" And I know we touched a little bit upon it but anyone want to jump in there?

Dr. Chapman: Obviously, the patients who cannot get access to legal pain medications have no choice and initially moved towards street drugs. But the street drugs beginning in about 2013, particularly heroin, began being laced with fentanyl. And that's what we saw here in Washington, D.C. So I think that with the fact that fewer pain medications were being prescribed between 2015 and 2020, that we saw somewhat of a leveling off and a decrease in overdoses from pain medication but obviously an increase, because the street drug supply changed dramatically, not only in Washington but it's changing dramatically across the country. And we have these illegal cartels who are businessmen who are actually following the trends and actually infiltrating communities where they know problems exist.

Dr. Agarwal: I'm going to go ahead and say one of the things a lot of people at least in the pain world argue is that some of what we're seeing is even though now new prescriptions are going down, some of the increased deaths as Dr. Chapman referred to are from people who previously had been prescribed opioids, perhaps inappropriately, and started misusing them. And then once they were no longer able to get their opioids of choice, then started moving street drugs. So there is an argument that part of this may be sort of this leftover effect from when we as physicians we're probably prescribing too much.

I mean, clearly, we still are prescribing too much. We just don't know that right balance. I mean, that is one of the arguments that's made, in addition to more time and resources. And for anyone who knows, I mean, resources to get mental health care and to get substance use care in this country is just really difficult and really challenging so some of this is just a leftover and that eventually we will actually start to see a decrease.

And then, of course, COVID has not helped anything for anyone and particularly children and adolescents, many have really had an increase in mental health issues. They're more isolated. There's all kinds of stuff that goes along with that. And substances are still really, pretty, relatively easy to get.

Dr. Chapman: I want to point out the role of housing. In Washington, D.C., we saw a tripling of overdose deaths among the homeless between 2015 and 2020. So we really can't disconnect how important housing, safe housing, is in terms of emotional stability. And we also know that among the homeless, we have a disproportionate number of people who are suffering from mental illness, as well

as substance abuse.

Dr. Mukkamala: Thank you. And that leads to another sort of thought-provoking and oftentimes quoted statistic or observation in the chat. It says, "Walter Williams, PhD, noticed that the loss of the family structure in black families from the '50s to the 2000s significantly corresponded to the social medical problems—crime, drug abuse, educational failure—that are being discussed." And sort of just ask for a comment.

I guess what I would say is that there are social determinants of health. Family unit changes themselves can be caused by further upstream disruptions that lead to that action, which then lead to the presence of substance use disorder. And so, I guess I would say let's not go a certain way upstream and say, "Okay, that's the cause." Let's go further upstream to figure out what it is that's causing that in this chain reaction that leads to it. But just curious if anyone else has any thoughts on that?

Dr. Chapman: I happened to grow up in the Midwest in Gary, Indiana, which like Pittsburgh was a steel city. My teenage years in the late '60s or early '60s at that time we had a number of families who moved further south to Gary, got good jobs and I can tell you that out of 400 graduates in my high school class, more than half went to college.

So, this economic link really has a lot to do with what we see. In the late '70s and '80s with the decline in the Rust Belt, then Gary declined economically and drugs infiltrated the community. So, you really have to ask the question what came first, the chicken or the egg?

Dr. Mukkamala: Thank you. Another case that was referenced in the chat about pediatric patients in a burn unit can't be given opioids for pain. Of course, it's not something that's verified but I certainly have observed even within my own surgical department that there's been a shift in our thinking. And partly as I mentioned, the CDC guidelines were sort of taken as dogma. And so, you know how that game where one person says something to one person and that person says it to another and by the time it gets 10 people down, it's totally different.

And so, the same way what sort of maybe started as a guideline has become dogma in our operating rooms and hospitals where now they're being told or we're being told not to prescribe. But just curious about your observations as far as how this ends up affecting us day-to-day when we're taking care of our patients?

Dr. Agarwal: I can answer that or try to answer that. That's not been true in any of the institutions I've worked at. And I do think that the presence of an active and strong inpatient pain team or acute pain team can really help prevent that. I mean, I understand and we would definitely work to try and minimize opioids in our burn patients. We would try to reserve them for when they were getting dressing changes or when they were getting other painful procedures done, because that's a such a

high cumulative dose of opioids that they can get. But we would also work on alternative medications in order to try and treat pain. And I think that's where having a pain team within the organization, whether it's pediatric or adult pain, to advocate for the patients and to advocate for care is so important.

And I agree and I've heard this from so many patients and physicians and practitioners that, again, I think a lot of it comes from the CDC guidelines that were taken completely out of context and out of the intention of the guidelines to say, "Well, they say you can't use this so we're not going to use this anymore." Rather than looking at this poor child or this poor young adult who's in excruciating pain and treating it appropriately because untreated pain we know has tremendous consequences.

Dr. Mukkamala: Thanks Rita. I guess one question specific to the pediatric population. How can we better help parents learn the effects of opioids so that in turn, we protect the children and adolescents from substance use disorder? So, through the parents approaching the care of the child.

Dr. Agarwal: So, whenever I prescribe opioids and I prescribe them frequently, I spend about a third of my time in our inpatient pain service. And whenever, even if I'm not prescribing it but the service that I'm consulting on prescribes them when they go home, it's not so much I can't really address all of the issues, but I really spend a good amount of time going over safe use, storage and disposal of opioids. If a child is at particular risk, if they have other mental health conditions that may contribute to that. If there's other things that may be going on, if there's a strong family history, I mean, those are kind of the main things that can increase the risk; although as we know everyone can be at risk.

I really talk about that with the families ahead of time, either depending on the age of the child, outside of the room or inside of the room depending again on how old. I mean, I deal with children from babies all the way to young adulthood. We see patients up into their early 20s. If it's a young adult and it's appropriate, I will talk with them as well but I really spend some time going through that and going through kind of what the resources are for disposing of the opioids, for making sure the parents have control over the opioids and that they're not left lying around on a counter somewhere where anyone can get to them.

I'm not a mental health specialist. I'm not a psychologist or a psychiatrist. So, beyond that, that's sort of my role in this. And I think it's an easy thing for any of us who do prescribe opioids to do is just to go over safe use and storage and disposal; particularly disposal.

Dr. Mukkamala: Thanks, Dr. Agarwal. Dr. Sedney, any comments?

Dr. Sedney: No, wholeheartedly agree. The other thing I'll say is I think that it's important to make sure that the patient's parents know that it's actually safe to take opioids in a perioperative period with those caveats. Because I often will have family members or parents of pediatric patients be very concerned and not want them to have anything. And so, some reassurance is sometimes in order.

Dr. Mukkamala: Thank you. There's a question in the chat about examples of jurisdictions that are getting it right, so to speak, where law enforcement, elected officials, addiction medicine experts are working together to optimize treatment and wiser policy. And so, looking for those examples, what I will say is that the AMA has a lot of resources so that this wheel doesn't have to be invented state by state, right? So, if we in Michigan want to do something we don't need to create that, we can look to other states.

And so, one example, for example, is the state of Maine who's really made great progress and efforts to ensure that medication for opioid use disorder is available in all jails and prisons; but this is coordinated advocacy. This is the solution to the problem. But again, it's a wheel that doesn't have to be invented. It exists in some of our states but does anyone have any comments about how things are going well in their areas or poorly?

Dr. Chapman: So, you very correctly mentioned what's called LEAD, L-E-A-D, Law Enforcement Assisted Diversion. Where instead of taking a person to jail, they're actually taken to a treatment center. That's number one. Number two: one of the problems we have is the fact that we don't have universal health coverage. We know that medication-assisted treatment is the standard of care, which means that anyone and everyone should have access to either methadone, buprenorphine or injectable naltrexone for treatment. Because without that, if a person is truly addicted, we know that within a year, there's a 90% relapse rate. And, of course, the risk of overdosing and dying.

And as Dr. Mukkamala as mentioned, we need to have better connection between the criminal justice system and outpatient treatment. But also, if a person overdoses and goes to the hospital, they should be started on medication-assisted medicine before they leave the emergency room. And that's still a work in progress in most jurisdictions.

Dr. Mukkamala: Thank you. We'll try to get a couple more questions in here. Any advice you would offer to parents who wish to mandate that their minor children receive inpatient therapy for opioid use disorder but are unable to do so due to legal restrictions? Dr. Agarwal?

Dr. Agarwal: I'm not sure. I mean, I thought if it's a minor child, honestly, I don't really know the answer to that question. I thought minor children could be. I think the real issue is still resources. I mean, I live in and practice in a very resource-rich area and I can tell you it's still incredibly difficult to get inpatient beds and to get rehab beds, particularly for minor children for the under 18 age group child.

So, I don't know that parents, I mean, I think parents can and some of it comes down to insurance and coverage but, honestly, I think it ends up being more of a resource issue than it is that they're able to do it or not do it.

Dr. Mukkamala: Yeah. I would echo those comments. I've heard stories just here in Southeast Michigan about young people waiting in emergency rooms for more than a week, but you know that if we had true parity, that wouldn't be the case. That person would get treatment just as quickly as if they had had a broken femur playing a basketball that they'd be taking care of that night. And so clearly just sort of speaks to absence of parity.

Any indications that nationwide marijuana legalization, cannabis legalization could have significant impact or not? I know that from the AMA's perspective, there's a lot more research needed before we can make that statement and that's going to include rescheduling of it. But any intersection of the conversations and laws around cannabis related to this from anybody?

Dr. Agarwal: I can't address the effect of specific laws, but I can say that an increasing number of our chronic pain patients, including children in California, I mean, it's not legal in children under 21, I think. I'm not 100% sure, it may be 18 but you can definitely get a prescription for a medical cannabis or medical cannabinoid products.

There's definitely increased usage and as a result, there's increasingly potent products on the market, which I think has the real potential to create problems. Beyond that, again, that's not really my expertise so I can't address that specifically.

Dr. Sedney: I'll agree with that. As a surgeon, it's impossible for patients to get chronic opioid prescriptions here. And so many of our patients have transitioned to medical marijuana. And anecdotally they say that it helps, but we'll have to wait for the evidence on it.

Dr. Mukkamala: Thanks. And obviously, folks with substance use disorder face a lot of stigma, including from their physicians. And so, what are the ways that you're addressing that? I see a lot of people that when these laws change, when the CDC guidelines sort of came out and were misapplied they said, "Okay, I'm done. I'm out of here." They're not prescribing anything. They're just sort of walking away and then stigmatizing those that are asking. What is your response or institutionally, what do you guys do for that?

Dr. Sedney: So stigma's something I'm pretty passionate about. And both substance use disorder and chronic pain are stigmatizing conditions. I think the first thing that's important to understand is that stigma isn't like some nebulous, soft topic. It is a very well-described sociological and anthropological phenomenon. And there's very good data on the definable negative effect of stigma on health outcomes, including stigma from health care workers. So we are susceptible to it.

And with that in mind, my organizations not doing anything but there are definitely some best practices to combat stigma; team-based care being one. Patient-centric communication is one. And educational interventions, particularly if they involve contact with someone from the stigmatized group. And I mean, we don't have any like organizational things but personally I have a talk that I give on stigma to

physicians and nurses and it's been well-received so.

Dr. Mukkamala: Thank you.

Dr. Chapman: One other thing that we're doing in Washington through the Department of Behavioral Health actually gave out a million dollars in grants to churches to really sponsor programs to educate the community. And during and before COVID, we were using Zoom actually, to bring those messages and really explain what addiction is, what the treatment modalities are, et cetera. And it's worked out very well. So, it's taking traction. But again, it's going to take time to undo 60 or 70 years of incarceration as treatment.

Dr. Agarwal: Family-centered care is something that we do a lot of. We have a very active pain service here at Lucile Packard Children's Hospital. And so, we do get a lot of inpatients with chronic pain. I mean, even though we all try, there's still a lot of stigma. There's still a lot of eye rolls. "Oh yeah, they're here for this."

And I would say the AAP in particular is really working on the language, the Committee on Substance Use Prevention. See, I almost said abuse there, is really working hard on the language around this to try and decrease stigma from things like addiction abuse, you're the problem, as opposed to this is a problem and we need to help take care of it.

Dr. Mukkamala: Thank you. And if you guys don't mind just spending just 30 seconds just for some closing thoughts. And then I'll wrap it up. Rita, you want to go first? Dr. Agarwal?

Dr. Agarwal: Sure. I think it's a really complex problem. I think everyone for signing in to listen to this because it's really going to take all of us, it's really going to take that village to come up with better solutions. I think it starts with increasing resources and increasing availability of treatment modalities and treatment options. And it ends with the ability to get those things paid for so that people can actually benefit from some of these other modalities to the treatment of pain.

Dr. Mukkamala: Thank you. Dr. Chapman?

Dr. Chapman: So I often wonder what have we learned from COVID with the fact that we know that getting treated for COVID actually not only treats ourselves but treats our neighbor. And it makes me think of a quote from Martin Luther King that, "We're all caught in an inescapable network of mutuality tied in a single garment of destiny. Whatever affects one directly affects all indirectly."

And this is a disease process that touches everything. I can't think of anything from neonatal abstinence syndrome to employment, to every aspect of life, criminal activity as the opioid epidemic. And the question is we have to approach it as a village.

Dr. Mukkamala: Thank you. Dr. Sedney?

Dr. Sedney: Yeah, I agree with everything that everybody said. I would just add that patients with substance use disorder and patients with chronic pain are a very vulnerable group. They have a lot of things stacked against them. And so rather than sort of viewing all these big societal issues when you see that person in front of you, try to see the person in front of you and treat them with kindness and care.

Dr. Mukkamala: Awesome. Thank you all for spending part of your busy workday with us. It's an honor to share the screen with you. In closing, let me say this. The status quo with more than 100,000 overdose deaths per year is unacceptable and we cannot normalize it. Substance use disorder doesn't discriminate. It affects the young, college students, seniors, wealthy, poor, people from all racial and ethnic backgrounds but we can treat it. We have the knowledge and tools necessary, and we owe it to our patients and their families to do everything possible to do that.

Many thanks to each of our panelists for joining us today. In our next webinar on 4/21 at 11:30 on surprise medical billing. So please join us there. Thanks everybody.

Disclaimer: The viewpoints expressed in this video are those of the participants and/or do not necessarily reflect the views and policies of the AMA.