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SPECIAL EDITION– OPIOID MISUSE DISORDERS AND TREATMENT

Introduction to Special Issue on Opioid Use Disorders and Treatment

Samuel Knapp, Ed.D., ABPP[1]

In early July 2017, Lycoming County first responders treated 55 individuals for heroin related overdoses in a 48-hour period. At least two died (Beauge, 2017). Such explosions of overdoses and death are becoming increasingly common in rural Pennsylvania.

The United States has an opioid problem. The Substance Abuse and Mental Health Services Administration (2014) estimated that 2 million Americans abused or were dependent on prescription opioids in 2014. In addition, deaths from opioid overdoses tripled from 1999 to 2015. Perhaps one quarter of these are listed as suicides, although it can sometimes be hard to distinguish an accidental from a deliberate overdose. Also, long-term opioid use increases the risk of premature deaths from cardiovascular disorders (Ray, Chung, Murray, Hall, & Stein, 2016) and diminish a patient's quality of life. The rate of drug overdoses in Pennsylvania is almost twice the national average and its rural counties have been impacted as hard as its urban counties (Drug Enforcement Administration, 2016).

[1] In August 2017, Samuel Knapp marked 30 years as the Director of Professional Affairs for the Pennsylvania Psychological Association.

Many blame the opioid problem on the prescribing patterns of physicians. Most patients who receive opioids for the short-term relief of pain suffer no significant side effects. A small percentage of patients prescribed opioids will need them for an extended time (Kroenke & Cheville, 2017), and one in four of those patients will have a long-term struggle with abuse (Boscarino et al., 2010).

Mendoza et al. (2016) commented that the recent focus on opioid abuse may reflect racial or class bias because similar drug epidemics among urban poor have not elicited the same kind of compassionate concern. They may be right, but the concern about the public health impact of opioid abuse is nonetheless legitimate.

I hope the articles in this special issue will help inform psychologists about this public health challenge. Readers can receive one (1) hour of continuing education from this issue (see instructions below).

The Substance Abuse and Mental Health Services Administration (2014) estimated that 2 million Americans abused or were dependent on prescription opioids in 2014.

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Essential Information about Opioid Use Disorders

Samuel Knapp, Ed.D., ABPP[1]

Opioids relieve pain by binding on the mu-opioid receptors in the brain that regulate pain perception and feelings of euphoria. In addition, these receptors can be found in other areas of the body, such as areas regulating respiration.

The Centers for Disease Control (CDC) classifies opioids into four categories: (1) natural or semi-synthetic opioid analgesics such as morphine, codeine, oxycodone (Oxycontin), and hydrocodone (Vicodin); (2) methadone; (3) synthetic opioid analgesics (such as tramadol and fentanyl); and (4) heroin. The FDA has approved 18 different opioid-based medications.

Tramadol and fentanyl are synthetic, high-strength opioids approved for treating severe pain. Although developed as a prescription drug, fentanyl is now being made and distributed illegally. Some opioids sold on the street are laced with fentanyl without the knowledge of the buyer. Entertainment superstars Michael Jackson and Prince both overdosed on fentanyl. Nationwide, the deaths from tramadol and fentanyl overdoses increased 72% from 2014 to 2015 (Rudd et al., 2016).

The Spread of Opioid Abuse

In addition to the increase in abuse and overdoses linked to prescription opioids, the rise in heroin use may be linked to the increase in opioid prescriptions. Only 4% of persons prescribed opioids will go on to use heroin (Institute of Medicine, 2011). Nonetheless, given the large number of patients who receive prescription opioids, this translates into well more than a hundred thousand new heroin users a year. In the last decade 75% of heroin users reported that prescription opioids were the first opioids that they used, in contrast to the 1960s where 80% of heroin users reported that heroin was the first opioid that they used (Compton, Jones, & Baldwin, 2016). Heroin is more accessible and less expensive than other opioids. It can be snorted or injected, thus providing a more immediate sense of euphoria (CDC, 2017). Heroin is especially problematic because the strength of the drug may vary, it may contain contaminants, and injecting it increases the risk of HIV or hepatitis C infections (Banerjee et al., 2016). Around 90% of heroin users will develop hepatitis C sometime in their lives (Connery, 2015).

In addition to the increase in abuse and overdoses linked to prescription opioids, the rise in heroin use may be linked to the increase in opioid prescriptions.

Some areas of the country, especially West Virginia, Ohio, and Pennsylvania, have seen sharp increases in the number of heroin users. One man from Middletown, Ohio,[2] stated that "everyone I know is on heroin." Middletown which was once proclaimed as an "All-American City" and heart of America's heartland, has seen heroin use and overdoses surge in the last five years (de la Bruyére, 2017).

The increase in heroin use has occurred across demographic groups, including women, those with private insurance, and those with higher incomes. It would not be unheard of to encounter a college educated, employed, white woman living in the suburbs who is using heroin. One middle class mother whose adult son died from a heroin overdose said, "I no longer judge drug addicts. . . I no longer judge prostitutes" (Quinones, 2015, p. 9).

Opioid Abuse and Prescription Practices

During the middle to late 1990s a combination of factors led to the over prescription of opioids. A movement focusing on assessing and treating patients for pain was the immediate catalyst. In 1999 the VA started an initiative called "Pain as the 5th Vital Sign" that required physicians to assess pain in each of their clinical encounters.[3] In 2000, the Joint Commission (formerly called the Joint Commission for the Accreditation of Health Care Organizations) required organizations to establish policies for assessing and managing pain (Baker, 2017).

Although nothing in these initiatives explicitly recommended opioids for pain reduction, it could be argued that an increase in opioid prescriptions would be expected because they were the drugs most widely used to control pain. Physicians were not well trained in how to manage pain. Many were not aware of behavioral interventions for pain or were working in a health care environment that had reimbursement obstacles for behavioral interventions. Also, science had not yet identified the extent of harm from extended opioid use, and pharmaceutical companies aggressively marketed opioids to physicians.

Sales of opioid analgesics increased 300% from 1999 to 2011. Almost two-thirds of those prescriptions were for short-term therapy (less than 3 weeks; Volkow et al., 2011) and most were for joint or back pain (Voelker, 2017). The rate of prescribing opioids increased especially among specialties dealing with chronic pain such as pain medicine, surgery, or rehabilitative medicine. However, primary care physicians prescribed between 50% and 70% of all opioids. The number of opioid prescriptions has declined slightly in recent years.

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[1] The author thanks Drs. Donald McAleer and Julie Radico for their assistance with this article.

[2] Middletown, OH was the primary location of the memoir, *Hillbilly Elegy* by J. D. Vance. Although heroin has a role in his family's dysfunction, it has become even more widespread since the events he chronicled in his book.

[3] The other vital signs were blood pressure, respiratory rate, heart rate, and temperature.

ESSENTIAL INFORMATION ABOUT OPIOID USE DISORDERS

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Physicians often have idiosyncratic prescribing practices. For example, Barnett et al. (2017) found that emergency room physicians differed significantly in how frequently they prescribed opioids, even when the characteristics of the patients appeared similar. Although the initial prescription written by an emergency room physician might have appeared to be of limited consequence, in and of itself, it may have led to "clinical inertia" whereby subsequent physicians continued to prescribe the opioid without adequately reviewing the medical necessity for the treatment. Those patients who had encountered high intensity prescribing physicians in the emergency room had higher rates of long term opioid use than patients who had encountered low intensity prescribing physicians in the emergency room.

The increase in the prescription of opioids has been accompanied by an increase in the non-medical or recreational use of prescription opioids. Although only a small minority of patients prescribed opioids will abuse them, some patients are especially vulnerable, including those with a history of substance abuse, uncontrolled pain, or emotional distress or who are adolescents or older adults. Adolescents have an increased risk for harm because of the neuroplasticity of their brains and their under-developed cortexes make them more prone to impulsive behaviors (Volkow & McLellan, 2017). In 2010, 6% of adolescents aged 12 to 17 had taken controlled pain medications for nonmedical purposes (Young et al., 2012).

Older adults also have a greater risk of misusing opioids, especially if they have a history of depression or substance abuse (Boscarnio et al., 2010). Furthermore, they are more likely to have serious pain, and their kidney and liver functions have slowed down, allowing drugs to remain in the system for longer periods of time. Nonetheless, no patient is immune from abusing a medication.

Patients who abuse opioids may steal or borrow them from friends or family members, receive prescriptions from more than one physician, or purchase them from drug dealers (Jones et al., 2014). Some older adults with limited incomes sell their opioid drugs to drugs dealers to supplement their incomes (Eaton, 2017). Often drug dealers will solicit or threaten older adults to sell their prescription pills; and then then resell them at a much higher price.

Some of the increase in the availability of opioids comes from opioid mills, but the large majority of opioids still come from legal prescriptions written by well-meaning physicians. While cracking down on opioid mills is essential, it is not sufficient to curtail the abuse of opioids.

According to Dr. Julie Radico, psychologist and Assistant Professor at Penn State Hershey Medical Center, "physicians often feel caught between competing demands. Patients want relief from pain, yet opioids involve health risks and do not always reduce long term pain" (Personal Communication, July 5, 2017).

Patients with polyneuropathy who received opioids were more likely to have a depression, opioid dependence, or have had an opioid overdose than those who received short-term prescriptions of opioids. In addition, their self-reported functional status was no better than those who received short-term prescription use of opioids (Hoffman, et al., 2017). Nonetheless, many patients and physicians believe that only opioids can control their severe pain, and many patients do not have access to professionals trained in non-medical treatments for chronic pain. Physicians feel pressure from patients to prescribe opioids, and simultaneously feel pressure to limit the opioids that they prescribe. At times, it appears that "policy and medicine are at odds with each other" (Webster, 2014, p. 346).

Part of the responsibility for overprescribing opioids rests with pharmaceutical companies which promoted bad science that extoled the benefits of opioids while downplaying their harmful side effects. Some earlier scientific publications claimed that the risk of abusing opioids was very low, even though the science behind those conclusions was weak. One 99-word letter to the editor of the *New England Journal of Medicine* (Porter & Jicks, 1980) concluded that "despite the widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction" (p. 123).[4] The letter was subsequently cited 901 times in Google Scholar and was referenced as "extensive," "landmark," and "persuasive," despite many extensive methodological shortcomings (Jacobs, 2016).

Purdue Pharma, the company that developed OxyContin received $1 billion in revenue in 1996, only a few years after their drug was introduced into the market. At one point OxyContin accounted for 90% of that company's sales. Eventually Purdue Pharma was forced to pay $600 million in fines for misinformation it gave to physicians (Meier,

[4] Here I am quoting the article and thus using the more traditional term "addiction," although many experts prefer non-stigmatizing language such as "use disorder" (Botticelli & Koh, 2016).

2007). Its sales representatives minimized OxyContin's addicting potential, and falsely informed physicians that patients receiving high doses could abruptly discontinue the drug without ill effects (Quinones, 2015).

The state of Ohio has joined several other jurisdictions in suing Purdue Pharma for the public harm it has created though it massive advertising campaign. Between 1996 and 2002 Purdue Pharma sponsored 20,000 continuing education programs for physicians which the plaintiffs argue were primarily advertisements for opioids given with a professional veneer that could pass for continuing medical education (Ohio High, 2017).

The responsiveness of physicians to this marketing campaign may have occurred, in part, because they lack in-depth knowledge of pain. The average physician received 11 hours of coursework on pain management in medical school, although some received only 1 hour (Davis & Carr, 2016). The amount of education they received on substance use disorders was similarly quite low. Dr. Donald McAleer, psychologist and partner with Northshore Psychological Associates in Erie, PA has noted this lack of knowledge among physicians. "When they think of psychologists, they think of treatments for depression and anxiety; not treatments for pain" (Personal Communication, July 5, 2017).

Mitigation Strategies

Risk mitigation strategies can reduce the risk of opioid use disorders. These include monitoring the patient's opioid use, using nonopioid pain reduction interventions, treating co-existing mental health and substance abuse disorders, and avoiding the co-prescription of opioids and sedatives. No one risk mitigation strategy is appropriate for every patient or every setting, however, together they can reduce the risk of an opioid use disorder.

Pain can best be described as "multidimensional, dynamic interaction among physiological, psychological, and social factors that reciprocally influence each other" (Edwards et al., 2016, p. T71).

Physicians now use Prescription Drug Monitoring Programs (PDMP) which are statewide data bases that collect information on the prescription of controlled substances. They monitor the prescription written for patients, and track patients who seek prescriptions from multiple providers. Physicians in Pennsylvania must report on prescriptions of controlled substances to the PDMP by the close of the subsequent business day (Pennsylvania Department of Health, 2017).

The CDC has issued the *Guideline for Prescribing Opioids for Chronic Pain* (Dowell, Haegerich, & Chou, 2016). These guidelines state, among other things, that: nonopioid treatment is preferred for chronic pain; opioids should be prescribed at the lowest clinically indicated level possible; physicians should avoid prescribing opioids and benzodiazepines at the same time; and physicians should evaluate long term opioid users every three months.

Veterans are likely to be prescribed opioids at a rate of seven times more than the American population in general. Consequently, the VA is investing heavily in the risk mitigation strategies reviewed above and it also requiring long term opioid users to receive urine screens, which will help determine if the patients are also using illegal drugs, or if they are not taking the drugs and perhaps diverting them to friends or family members. The VA procedures have reduced the rate of drug overdoses in half from 2010 to 2015 (Gellad, Good, & Shulkin, 2017).

What About Pain?

Concerns about opioid use disorders risk overshadowing the continuing problem of helping patients manage chronic pain. Von Korff et al. (2016) reported that 14% of patients had severe chronic pain often occurring in multiple locations, and about 20% of these patients were receiving opioids to help control their pain.

Efforts are underway to develop non-addicting pain reducing drugs. However, I have been disappointed that the National Institute of Health appears to be focusing exclusively on medical interventions for pain and ignoring non-medical interventions (Volkow & Collins, 2017). Pain can best be described as "multidimensional, dynamic interaction among physiological, psychological, and social factors that reciprocally influence each other" (Edwards et al., 2016, p. T71). It is, in my opinion, poor science to ignore the psychological and social factors that contribute to pain. Fortunately, other commentators, such as Volkow and

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McLellan (2017) appreciate the importance of non-medical interventions such as specialized psychotherapy, meditation, or biofeedback. Even the revised standards of the Joint Commission recommend looking at psychosocial risk factors for chronic pain and for exploring nonpharmacological options for pain management (Baker, 2017). Behavioral interventions are hindered by the lack of qualified persons to administer them and by reimbursement patterns that favor pharmacological interventions. It is true that behavioral interventions do not work well for all patients with chronic pain, but "imperfect treatments do not justify therapeutic nihilism" (Kroenke & Cheville, 2017, p. E1).

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Brief Notes on the History of Opioid Habits, and Abuse in the United States

Samuel Knapp, Ed.D., ABPP

Opium has been part of human society for many centuries. Archaeological digs have found evidence of opium use as far back as 4,000 BCE (Quinones, 2015). Physicians in colonial America frequently used opium for a wide range of problems. Among its uses, opium could control coughing, often a sign of the fatal tuberculosis disease. Even one of the side effects of opium, constipation, had a therapeutic benefit in that it could control diarrhea, another common cause of death.

The use of opioids increased during the American Civil War, especially by surgeons who had to remove limbs from soldiers injured during battle. The surgeries were brutal, and effective surgeons were those who could remove the limbs most quickly, thus reducing the likelihood that the patient would die from shock. Many Civil War veterans, both North and South, became addicted to opiates such as opium or morphine (Quinones, 2015).

The use of opiates in the United States increased for several reasons. First, the hypodermic needle was introduced in 1856 which allowed patients to feel the benefits of opium more quickly. Second, physicians of the time often prescribed opiates for a variety in ailments, largely because they had few pharmaceutical options available to them. Finally commercial drug manufacturers, which were unregulated at the time, commonly put opiates in their over-the-counter medications. In 1898, heroin was introduced as an overt-the-counter medication to control coughing. (Courtwright, 2001).

The 1906 the Pure Food and Drug Act required manufacturers to identify the ingredients in their medicines.

Eventually the physicians who once recommended opiates liberally began to discover that many of their patients had acquired an opium "habit." Those at the higher socioeconomic levels of society who could afford to go to physicians were more likely to develop the opium habit. Those at the lower socioeconomic levels of society did not have the "benefit" of access to physicians and were less likely to develop the habit. The link between opioid misuse and prescribing patterns of physicians would reoccur more than 100 years later.

By 1900 physicians began to have more options for understanding and treating disease. By this time the germ theory could explain many diseases, and effective medical treatments for many diseases became more available. Aspirin, another medication to control pain, was introduced in 1899. X-rays would soon be available as well.

The 1906 the Pure Food and Drug Act required manufacturers to identify the ingredients in their medicines. Many partakers of over the counter patented medications learned that they had been taking opiates. The 1914 Harrison Act restricted the use of opium to medical purposes, and in 1919 its provisions were interpreted to prohibit physicians from prescribing opium simply to maintain those who had a habit. The opioid habit of the White upper class gradually became the opioid addiction of the lower classes. During the 1920s many addicts supported their habit by looking for scraps of copper, lead, zinc and iron in industrial waste dumps, thus earning themselves the name junkmen or "junkies" (Courtwright, 2001).

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Professional Psychologists and Opioid Misuse

Samuel Knapp, Ed.D., ABPP[1]

Some psychologists, such as those who work in chronic pain centers or in the treatment of substance abuse, regularly encounter issues surrounding opioid use or abuse. But even psychologists in a general outpatient practice will likely encounter patients who are taking opioids, are abusing opioids, or had been abusing opioids. This article reviews some essential information that generalist outpatient psychotherapists should know about opioids and opioid use disorders, and how to respond when they are treating patients who appear to be abusing opioids.

Screening All Patients

I recommend that outpatient psychotherapists ask all their patients about the pharmaceuticals (both prescription and nonprescription, legal and illegal) they are taking, any history of substance abuse, their current physical health (including any chronic pain), and legal history. An arrest involving drugs or DUI raises high concerns for a substance use disorder. Many psychologists include such questions on a form given the patients before treatment begins, but it is prudent to follow-up if the responses raise any concerns.

Patients Taking Opioids

Psychologists will encounter patients who have been prescribed opioids appropriately for the short-term relief of pain. Most of these patients will not abuse these drugs.

Also, psychologists will encounter patients who have been prescribed opioids for chronic pain. Although the effectiveness of opioid prescriptions for the long-term control of noncancer pain is not well-documented, many competent physicians believe that a minority of patients will benefit from the long-term use of opioids, and some patients express great fear of discontinuing those drugs.

Psychologists treating patients who are taking opioids for chronic conditions can monitor them for common psychological side effects of opioid use: sleepiness, dizziness, confusion, and depression. The long-term use of opioids may induce depression in some patients who had no previous history of depression (Scherrer et al., 2017). The biochemical properties of the drug may cause the depression, although physical inactivity or social isolation may contribute as well.

Most patients who take opioids for chronic conditions do not abuse them. The risk of abusing opioids increases for patients who have uncontrolled chronic pain, extreme emotional distress, or a history of substance misuse (Stumbo et al., 2017). Habits of misusing opioids and other substances can often go through periods of exacerbation and remission. Patients may have long periods of abstinence, although they risk abusing opioids again, especially if they experience unusual pressures or emotional strains (Schuckit, 2016).

If patients using opioids show signs of mental deterioration consistent with opioid use or begin to misuse prescription medication (such as hoarding pills, forging prescriptions, purchasing pills from illegal sources, etc.), then it would be appropriate for the treating psychologists to consider the presence of an opioid use disorder. In those cases, it would be indicated to have a frank discussion with patients about the possibility of specialized treatments.

Some interventions such as the SBIRT (screening, brief intervention, and treatment; for more information see SAMSHA, 2017) or motivational interviewing (see website at http://www.motivationalinterviewing.org/) have had success in screening or motivating such patients. SBIRT is a protocol designed by SAMSHA to identify patients with substance abuse disorders and to refer them if necessary. SBIRT incorporates many of the elements of motivational interviewing.

Psychologists treating patients who are taking opioids for chronic conditions can monitor them for common psychological side effects of opioid use: sleepiness, dizziness, confusion, and depression.

Patients do not always represent their drug use accurately to their treating professionals. In part this occurs because denial is a common feature of drug abuse. However, other patients may feel shame at their behavior. They may have adopted common negative societal stereotype that persons who abuse drugs are morally weak. Or they may assume that the only treatments will be dehumanizing and unnecessarily confrontational. Both SBIRT and motivational interviewing try to reduce defensiveness by adopting a non-judgmental and caring approach.

Both procedures are collaborative. Psychologists appreciate that the patients are the authorities on their own lives and respect the patient's experiences and interpretations of events. In motivating interviewing, for example, psychologists would not freely give their advice to their patients, but would give it in response to a direct question from a patient or would ask the patients permission to give their opinions.

Both approaches acknowledge the need for patience. Often patients are not willing to accept the possibility that they have an abuse disorder (according to the Stages of Change model, they would be in the pre-contemplative stage), but that does not mean that the interview was a failure, if the

Continued on page 10

[1] The Author thanks Dr. Chad Coren for his assistance with the article.

Continued from page 9

patients left feeling that they were treated respectfully and that their psychologist cared about them. It leaves the door open for future conversations. Evidence suggests that these interventions can be effective in reaching their goals (Bray et al., 2017; Society of Clinical Psychology, n.d.).

Opioid Abuse Treatment Options

Relatively few psychologists have expertise in treating patients with substance abuse disorders. Consequently, most psychologists who identify patients with these disorders should refer them to specialists.

The harm-reduction approach adopts a lower threshold for accepting patients into treatment and would consider working with patients on life changes even if, at this point, they were not ready for abstinence.

At the risk of great oversimplification, treatment on substance use disorders could be divided into two approaches with differing philosophies. The traditional medical approach sees abstinence or medication-assisted control as the only pathway to recovery. The harm-reduction approach adopts a lower threshold for accepting patients into treatment and would consider working with patients on life changes even if, at this point, they were not ready for abstinence. Harm reduction strategies "support any steps in the right direction" and "the harm reduction practitioner seeks to meet with the client where he or she is in regard to motivation and ability to change" (Logan & Marlatt, 2010, p. 201).

Some patients who are abusing opioids may need detoxication services that require withdrawal under medical supervision. Withdrawal symptoms include sweating, restlessness, increased pulse rate, joint pains, runny nose, upset stomach, tremors, goose bumps, and anxiety or irritability (Schuckit, 2016). Physicians may prescribe long-acting oral opioids such as methadone, extended use naltrexone, or buprenorphine to reduce the symptoms of withdrawal. Other medications may be prescribed to address specific withdrawal symptoms.

After withdrawal, many patients benefit from medication-assisted treatment. Physicians may maintain recovery by prescribing methadone, naltrexone, or buprenorphine, although the outcome with naltrexone has not been as positive as that with the other medications. Although these medications have opioids in them, they stabilize the physiological processes that were disrupted by the abuse of opioids (Volkow & McLellan, 2017). Some programs will keep patients on the methadone for buprenorphine for one year before weaning them off, although other programs will keep patients longer (sometimes recommending life-long participation in the programs). The good medication assisted programs include behavioral intervention help to ensure abstinence from opioids, such as self-help groups, patient education, or group or individual psychotherapy.

But patients often balk at these traditional treatment options. Some patients are not yet at the point that drugs interfere much in their lives. Or they may fear that going off the opioids would mean that their chronic pain would only get worse. Others assume that the only treatment option is to stay in an expensive, highly regimented, and confrontational 28-day residential program. They worry that agreement to treatment means a loss of control over the treatment decisions. Still other patients strongly resist the stigma of being an "addict," and the shame associated with that label, including the implication that they are morally defective in some way. Many patients do not want to participate in 12-step programs because they or a relative may have had bad experiences with 12 step programs in the past.

According to Dr. Chad Coren, a psychologist from Doylestown, PA specializing in the treatment of substance abuse disorders, "some patients may not be ready for abstinence, but may be willing to make some changes to improve the quality of their lives." Dr. Coren works with these

But patients often balk at these traditional treatment options. Some patients are not yet at the point that drugs interfere much in their lives. Or they may fear that going off the opioids would mean that their chronic pain would only get worse.

patients to reduce the most harmful effects of abusing substances, even if they are not yet ready to give up harmful drugs altogether. Psychotherapists working from the harm-reduction model avoid the "take-it-or-leave-it" approach to treatment, and work to understand the concerns of the patients and encourage them to consider their goals in life and how to reach them. Using the strategies found in motivational interviewing, they may ask the patients to make minor, but significant, changes in their behavior. For example, they and the patient may agree that the patient will cut back on the number of opioids used in one day (or a week). Or they may discuss with the patient the importance of having Narcan available or the implications of opioid use on their driving.

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Opioid Overdoses, and Suicide

Samuel Knapp, Ed.D., ABPP[1]

In a funeral in Selingsgrove, PA, parents shared the poems of their 23-year old daughter who died from a heroin overdose. She wrote, "I remember feeling like I lost all hope. . . I remember only causing pain, destruction, and harm" (Parents Share, 2017).

Drug overdoses are now the leading cause of accidental death within the United States. The number of drug overdoses in the United States has tripled since 1999 and, of the 52,000 drug overdoses in 2015, 63% involved opioids, with sharp increases in fentanyl and heroin-related deaths (Rudd et al., 2016). Overdoses from heroin have increased five-fold from 2001 to 2013 and tripled from 2010 to 2014.

The risk of an accidental overdose increases if patients are receiving the maximum daily dose of opioids, have co-existing substance abuse problems, and were also taking benzodiazepines. Perhaps one quarter of these overdoses are suicides. In addition, the number of non-fatal opioid overdoses requiring treatment in a hospital or emergency room has increased by a factor of six in the last 15 years (Knowlton et al., 2013). Nonfatal overdoses often cause brain or nerve damage (Madras, 2017).

The increase in drug overdoses varies geographically within the United States. States in the middle Appalachian region are especially hard hit. Pennsylvania is sixth among all states in the rate of drug overdose deaths (West Virginia is the highest in the country, while Kentucky is third and Ohio is fourth; CDC, 2016). The rate of fatal drug overdoses in Pennsylvania has almost doubled since 2010 (Rudd et al., 2016).

Opioids cause death by their effect on receptors in the brain stem that control breathing. Benzodiazepines are problematic because they also depress the functioning the respiratory system. Street drugs are especially dangerous because the seller of the drug, either knowingly or unknowingly, does not always accurately represent the nature and strength of the drug. Consequently, a user might fatally overestimate the amount of drug necessary to achieve the desired physiological reaction.

Heroin users have a high rate of mortality either from overdoses or from a constitution weakened by the prolong use of heroin. One longitudinal study found that Australians who habitually took heroin had an average age of death in their late 30s and an average life expectancy of 43.5.

First responders can administer Naloxone to prevent many drug overdoses by preventing respiratory failure. A user-friendly intranasal version has been developed (Narcan Nasal Spray). However, someone must administer the drug. In addition, Naloxene may not be effective with very high doses of opioids or overdoses caused by fentanyl (Volkow & Collins, 2017).

Heroin users have a high rate of mortality either from overdoses or from a constitution weakened by the prolong use of heroin. One longitudinal study found that Australians who habitually took heroin had an average age of death in their late 30s and an average life expectancy of 43.5. Overdoses accounted for half of the deaths including 13% which were suicides (Darke et al., 2016). Patients who have been recently released from drug treatment centers have a pronounced risk of over dosing. Although they may have an intense desire to take the drug, they have lost the physical tolerance that once allowed them to take high doses of the drug (Volkow & McLellan, 2017).

Patients who are prescribed opioids have an increased risk to die from suicide. More than one-fourth of patients being treating for opioid abuse disorders had a previous suicide attempt (Bogdanowicz et al., 2016). However, it is hard to separate the unique effects of opioid use from other risk factors such as the presence of uncontrolled pain (Campbell et al., 2016), or co-occurring substance use or mental health disorders. Nonetheless, Ashrafioun et al. (2017) found that opioid misuse was related to suicidal behavior even when overall health ratings, depression, anxiety, and the abuse of other substances was controlled, suggesting that opioid misuse has an impact on suicidal behavior independent of other co-existing predictors of suicide.

It is often hard to distinguish between an accidental and intentional death, and many overdoses listed as accidental may have been intentional (Bogdanowicz et al., 2016). Both accidental and intentional deaths usually involve more than one drug, such as alcohol, marijuana, heroin or other illegal drugs, or other prescription medications, especially benzodiazepines (Yarborough et al., 2016). Also, those who had accidental overdoses often shared characteristics with those who had intentional overdoses: chronic pain, the lack of stable resources and consistent family support (Yarborough et al., 2016), a history of suicide attempts, the abuse of three or more substances, a history of depression (Bohnert et al., 2011), and a habit of injecting drugs (Artenie et al., 2015). Perhaps the repeated self-injections habituated drug users to pain and reduced the natural inhibition against self-harm (Joiner, 2005).

Much is unknown about the direct pathway between substance abuse and suicide. It is possible that some patients will use drugs to bolster their courage to kill themselves. After taking the drug they will increase their "courage" to kill themselves through hanging or shooting themselves. For other patients, the drugs may simply lower their self-control and make them more vulnerable to impulsive acts. For still other

Continued on page 12

[1] Portions of this chapter were adopted, with permission, from a forthcoming book *Suicide: Assessment, Management, and Treatment* by Samuel Knapp.

OPIOID OVERDOSES, AND SUICIDE

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Health professionals can reduce overdoses by screening patients for suicidal ideation or for risk factors or warning signs for suicide; educating patient about the problems associated with mixing opioids and other drugs; and ensuring good follow-up services for patients recently released from drug treatment facilities.

patients, the drugs might simply be the most accessible method to kill themselves.

Health professionals can reduce overdoses by screening patients for suicidal ideation or for risk factors or warning signs for suicide; educating patient about the problems associated with mixing opioids and other drugs; and ensuring good follow-up services for patients recently released from drug treatment facilities. On a public health level, it is good for first responders to have naloxone if they encounter an individual experiencing an overdose. A study within the VA Hospital system showed that suicide rates by drug overdoses were lower in facilities that required more drug screens, provided more follow-up appointments after new prescriptions were written, and had lower rates of co-prescribing sedatives, such as benzodiazepines (Im et al., 2014).

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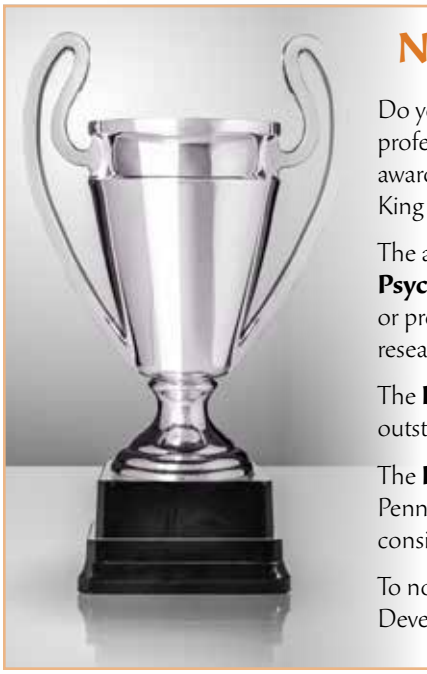

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Do you know of a colleague that has distinguished himself or herself as an outstanding professional psychologist? If so, we invited you to nominate that person for a PPA award! These awards, will be presented at the PPA2018 annual convention at the Doubletree Valley Forge in King of Prussia, PA.

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To nominate a deserving psychologist by Nov. 20 or for more information, contact Professional Development Specialist Judy (Smith) Huntley at 717-232-3817 or judy@papsy.org.

CE Questions for This Issue

The articles selected for one (1) CE credit in this issue of the Pennsylvania Psychologist Update are sponsored by the Pennsylvania Psychological Association. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists PPA maintains responsibility for this program and its content. The regulations of the Pennsylvania State Board of Psychology permit psychologists to earn up to 15 credits per renewal period through home study continuing education. If you have more than 30 continuing education credits for this renewal period, you may carry over up to 10 credits for into the next renewal period.

You may complete the response form at the end of this exam, making certain to match or answers to the assignee question numbers. Each question has only one right answer. Be sure to fill in your name and address, sign your form, and return the answer sheet to the PPA office with your CE registration fee (made payable to PPA for $20 for members ($35 for nonmembers) and mail to:

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Learning objective: At the end of the program the participants will be able to:

1. Describe essential information about the opioid epidemic; and
2. identify information that psychologists need to know to treat patients at risk of becoming addicted to opioids
3. describe opioid overdoses.

Introduction to Special Issue

1. Which of the following are TRUE?
   a. Deaths from opioid overdoses tripled from 1999 to 2015
   b. The rate of opioid overdoses in Pennsylvania is twice the national average
   c. Long-term opioid use increases the risk of cardiovascular disorders
   d. All the above

Essential Information about Opioid Use Disorder

2. Compared to prescription opioids, heroin is especially problematic because
   a. It is likely to have contaminants
   b. It can cause serious infections if injected
   c. The strength of the drug might vary if purchased in the street
   d. Al the above
3. A person who has an opioid use disorder may prefer heroin because it
   a. Is cheaper and more easily available than other opioids
   b. Prevents getting addicted to other drugs
   c. Has none of the side effects found in other opiates
   d. All the above
4. Many physicians did not have a good understanding of pain management and were too quick to believe the exaggerated claims of opioid drug manufacturers.
   TRUE FALSE
5. Dr. Smith saw a patient who had been prescribed opioids by an emergency room physician the night before. Dr. Smith assumed that the ER physician knew what she was doing and did not conduct a thorough evaluation to determine the appropriateness of continuing the prescription and simply renewed it. This is an example of
   a. Learned helplessness
   b. Clinical inertia
   c. The fundamental attribution error
   d. All the above
6. Mitigation strategies include
   a. Avoiding the prescription of benzodiazepines and opioids for the same patient
   b. Offering non-medical interventions for chronic pain
   c. Monitoring patients who have long-term prescriptions of opioids
   d. All the above

What Psychologists Should Know About Opioid Use Disorders

7. The types of behavioral interventions that the author cites to supplement treatment of opioid use disorders include
   a. Patient education
   b. Self-help groups
   c. Individual or group psychotherapy
   d. All the above
8. Research on the use of opioids show that
   a. Most patients prescribed opioids went on to abuse heroin
   b. Depression sometimes occur among patients with long term prescriptions of opioids, even in the absence of a history of depression
   c. New advances have made heroin use disorders a very easily treated disorder
   d. Once patients have stopped abusing opioids they never relapse
9. An effective treatment of an opioid use disorder is medication assisted treatment such as through methadone.
   TRUE FALSE

History of Opioid Abuse

10. Earlier in American history opioids were commonly prescribed by physicians to control
    a. Diarrhea
    b. Typhoid fever
    c. Small pox
    d. All the above

Opioid Overdoses and Suicide

11. It is especially dangerous to mix benzodiazepines and opioids because benzodiazepines
    a. Are "uppers" while opioids are "downers"
    b. Frequently caused psychotic reactions
    c. Like, opioids, tend to depress the functioning of the respiratory system, thus increasing the risk of a respiratory system shut down and death
    d. All the above

12. The author states that patients who were recently released from an inpatient or residential drug treatment center have an increased risk of dying from a drug overdose because
    a. Their bodies have lost the physical tolerance to high doses of drugs
    b. They have severe depression after leaving their friends in the facility
    c. The contacts they made in the facility make it easier for them to get illegal drugs
    d. All the above

13. The emergency administration of Naloxone may NOT always be effective in preventing an overdose when patients have taken fentanyl or other extremely powerful opioid substances
    TRUE FALSE

14. Factors that increase the risk that a patient who had abused substances may die from suicide include a
    a. Co-existing phobias
    b. A pattern of self-injecting drugs
    c. A college education
    d. All the above

Continuing Education Answer Sheet

The Pennsylvania Psychologist Update, October 2017

Please circle the letter corresponding to the correct answer for each question.

1.	a	b	c	d		**8.**	a	b	c	d
2.	a	b	c	d		**9.**	T	F		
3.	a	b	c	d		**10.**	a	b	c	d
4.	T	F				**11.**	a	b	c	d
5.	a	b	c	d		**12.**	a	b	c	d
6.	a	b	c	d		**13.**	T	F		
7.	a	b	c	d		**14.**	a	b	c	d

Satisfaction Rating

Overall, I found this issue of the *Pennsylvania Psychologist Update:*

Was relevant to my interests	5	4	3	2	1	Not relevant
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Comments or suggestions for future issues _____

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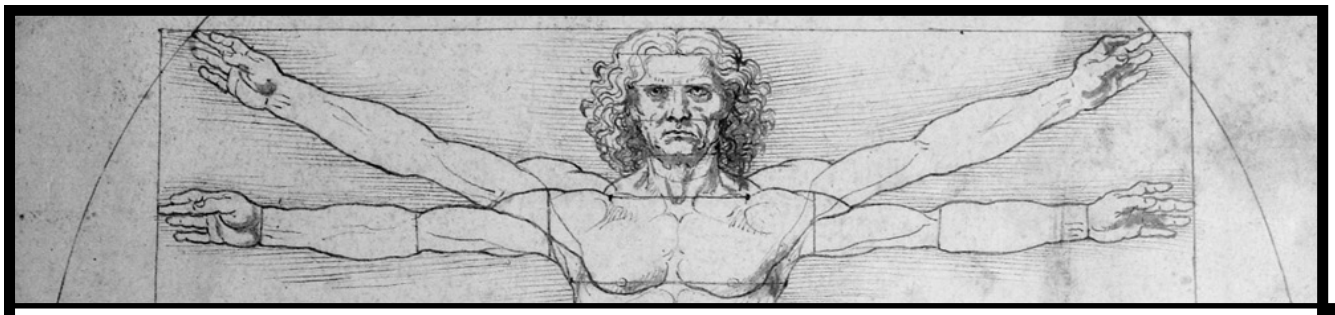

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Rachael Baturin, JD, MPH—PPA Office

October 26–27, 2017
Fall Continuing Education Conference
Eden Resort Inn, Lancaster, PA

October 30, 2017 • noon–1:30 p.m. and
November 6, 2017 • noon–1:30 p.m.
The Darker Side of Ethics and Morality in Psychological Practice
John Gavazzi, PsyD, ABPP—PPA Webinar

November 17, 2017 • noon–1:30 p.m. (1.5 ethics credits)
When to Ethically Break Confidentiality
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General

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