EAPs and the Opioid Crisis

By Bernie McCann, PhD, CEAP

[Originally published in the Journal of Employee Assistance, Vol 47, No.3:(16-19,34), 3rd Quarter 2017]

What are Opiates and Opioids?

The wide spectrum of narcotic substances incorporates both legitimate pain medications and illicit substances. While they share many physiological and psychological effects, these substances have different origins and routes to initiation. Opiates such as morphine, heroin, and codeine are derived from opium harvested from unripe poppy seed pods. At one time, opioids referred to synthetic opiates only (chemical preparations created to simulate opium). They are collectively known as pharmaceutical opioid analgesics, or simply prescription pain medications and include opioids such as hydrocodone (e.g., Vicodin®) and oxycodone (e.g., OxyContin® and Percocet®). Today, the term opioid is now used for the entire family of opiate-like drugs, regardless of whether they are natural, synthetic, or semi-synthetic.

The Current Crisis in Opioid Use

Increasing media coverage and a growing body of epidemiological studies have raised awareness about the alarming rise in abuse, addiction, and deaths from both illicit and prescription opioids. In the U.S., the number of deaths from opioid overdoses continues to rise, reaching more than 33,000 in 2015, which was the highest number ever recorded. Opioids, which include prescription drugs and illicitly manufactured heroin and fentanyl, accounted for more than 60 percent of all 2015 drug-related overdoses. Even more revealing is the statistic that 91 Americans die every day from an opioid overdose. (Centers for Disease Control and Prevention, 2017).

Nor is this issue confined within national borders, as Canada has become the world's second-largest consumer of prescription opioids, after the United States. Opioid-related deaths have quadrupled in the province of Ontario, and doubled in British Columbia. While North America's rate of adult opioid use is far ahead of any European country, opioids and sedatives have been identified as the most prevalent substances in prescription drug abuse in Europe. Globally, these substances account for the highest illicit drug-related burden of disease (Degenhardt, et al., 2013).

The increase in the nonmedical use of these medications has emerged as a major health problem among a broad spectrum of ages, geographic locations, and social classes. In fact, prescription opioids are the most frequently abused class of drugs in the U.S. The impact of this phenomenon on the US healthcare system is further demonstrated by the five-fold increase in admissions for opioid addiction over the past decade and a *150 percent* rise in emergency department visits involving prescriptions or illicit opioids. Increasingly, EAPs are encountering cases of opioid abuse and addiction among covered workers and their family members.

How Did We Get Here?

Due to increased awareness of chronic pain, support from organizations that treat pain, changes in medications, treatment guidelines, and alleged aggressive marketing by pharmaceutical companies, prescriptions for opioid pain medications (such as hydrocodone and oxycodone) have quadrupled since the 1990s. These drugs override the brain's decision-making center and are associated with acute physical withdrawal symptoms, which can for some individuals can create a high risk for abuse or addiction. Prescription opioid addiction can occur when patients develop a tolerance for the medication as prescribed and no longer get the same level of relief. The relatively rapid emergence of chemical tolerance toward more easily obtainable opioids (both prescription and illicit) has resulted in an increased incidence of abuse, dependence, and overdose fatalities.

In the U.S., an estimated two million people currently meet DSM-IV criteria for abuse or addiction to prescription opioid pain relievers. Close to half (44 percent) of Americans know someone who is addicted to a prescription pain reliever (National Safety Council, 2017). The numbers of those who abuse these

substances, while historically high, has declined slightly since 2014, a result of various efforts to more closely monitor opioid prescriptions. Unfortunately, an unintended consequence of these measures has been an escalation in users' transition to heroin, which in many areas has become cheaper and easier to obtain than prescription opioids. Consequently, while the numbers of those misusing prescription pain relievers may have begun to level off, the number of overdose fatalities from heroin and other illicit street opioids, such as fentanyl continues to rise and numbers of individuals suffering from heroin addiction have climbed above the 500,000 mark (Kolodny, et al., 2015).

Demographic Changes in Opioid Use are Striking

One of the clearest changes in the new face of opioid abuse involves a major sociodemographic shift among users into the adult working population. In 2015, prescription opioid misusers were typically non-Hispanic white, middle class older adults (aged 26-50), and living outside large urban areas. And not surprisingly, the majority of prescription opioid-related emergency visits, treatment admissions, and overdose deaths have occurred among adults over 26 (Cicero, Ellis, Surratt & Kurtz, 2014; Hughes, et al., 2016).

Changes in gender of abuse of prescription opioids is also evident. Deaths and treatment admissions from these medications have risen faster for females, who are more likely to have chronic pain, to more frequently be prescribed prescription pain relievers, to be prescribed at higher doses, and use them for longer periods of time, and may be become dependent more rapidly than men. Males are still more likely to overdose on prescription opioids, but the gap between genders is closing (Centers for Disease Control and Prevention, 2013). The surge in new users of heroin bears also has significant differences from earlier patterns in the 1960s-1980s, during which users were typically young minority men from urban centers. Current users are more likely to be white, equally male or female, and in their late 20s living in suburban or rural locations (Perkins & Shannon, 2016).

Those at Higher Risk for Opioid Abuse and Related Health Conditions

Risk factors for opioid abuse and addiction include family history of substance abuse, age, multiple psychosocial stressors, frequent contact with high-risk individuals and environments, history of thrill-seeking behavior, smoking, severe depression or anxiety, and previous drug or alcohol rehabilitation. However, some additional factors identified with risky opioid abuse and addiction are notable:

The connection to chronic pain – More than 90 million Americans (approximately one-third of the U.S. population) show symptoms of chronic pain, which is responsible for 25 percent of missed workdays and $100 billion in annual costs (Jamison, Serraillier, & Michna, 2011). Many first-time heroin users report they began their opioid use with prescription pain medications and changed to heroin when the medications became more difficult to obtain (Jones, 2013). Some individuals may alternate between these substances when one is more readily available than the other to avoid withdrawal symptoms.

Existing mental health conditions – Individuals with mood disorders and post-traumatic stress disorder who self-medicate are at higher risk for substance and opioid use disorders. Best practices with mood disorder patients at greater risk for misuse can incorporate case management protocols such as motivational counseling, opioid agreements, regular or random toxicology screens and compliance checklists, as appropriate (Quello, Brady, & Sonne, 2005).

Multiple drug users – Nine in 10 people who use heroin use it with at least one other drug, and many with at least two other drugs. Comprehensive assessments of individuals reporting multiple substance abuse experiences may assist in identifying more high-risk individuals, especially since this pattern of uses poses greater potential of overdose, health complications such as HIV and hepatitis infections, and other dangerous behaviors. Additionally, contemporary heroin users report greater use of other substances such as alcohol, other opiates, cocaine, amphetamines, and hallucinogens, and this suggests these users may have a higher risk for treatment dropout, relapse and difficulty attaining and maintaining recovery (Perkins & Shannon, 2016).

Accidental death by overdose – Worldwide, an estimated an estimated 70-100,000 people die from opioid overdose annually (United Nations Office on Drugs and Crime, 2013). The increased use of both prescription and illicit opioids is significantly associated with a greater threat of accidental death by overdose. More recently, drug overdoses involving synthetic opioids have multiplied, most likely due to the emergence of illicit fentanyl, which is often combined with heroin or sold as heroin, posing a lethal threat to inexperienced users. While overdose deaths between 1999-2015 increased for all age groups, the greatest increase for 2015 was in adults aged 55-64, although since 2005 adults aged 45-54 showed the highest overall rates of fatal overdoses (Centers for Disease Control and Prevention, 2017).

Current Approaches to Treatment

Today, there are three different FDA-approved medications and several evidence-based counseling approaches are available to treat opioid dependence. One of the biggest problems in addiction treatment is preventing relapse, and incorporating medications can ease cravings and withdrawal symptoms that may trigger relapse. Medication-assisted treatment, particularly when combined with psychosocial therapies such as 12-step groups, motivational counseling, behavioral therapies, recovery support and relapse prevention efforts effectively decrease opioid use, reducing opioid-related overdose deaths and infectious disease transmission. Available medications include buprenorphine and naltrexone which have expanded choices beyond the more traditional methadone, first introduced in the 1960s. Unfortunately, residual stigma to these evidence-based treatments persists, based on the misunderstanding that these medications substitute one addiction for another. More accurately, they do not produce euphoria but rather ease withdrawal symptoms and restore balance to the brain circuits affected by addiction (American Society of Addiction Medicine, 2013; National Institute on Drug Abuse, 2016).

Unfortunately, not all insurance plans cover all available opioid treatment options. According to a recent survey of mental health and substance abuse benefits offered by work organizations, 91 percent included some type of mental health/substance abuse benefit, including EAPs. Of organizations providing substance abuse treatment benefits, 89 percent cover outpatient sessions, 85 percent covert inpatient treatment while only 67 percent cover prescription drug therapies. Additionally, except for online access (56 percent) less than half of surveyed work organizations offered education and awareness resources regarding substance abuse prevention or treatment to workers (International Foundation of Employees Benefit Plans, 2016).

Our current understanding of the disease mechanism for substance use disorders and the effectiveness of evidence-based treatment for opioid dependency reinforces the understanding that addictions are chronic conditions for which there are useful treatments but rarely simple cures. EA professionals have an ethical responsibility to be knowledgeable about these treatments and to present them as viable options to clients.

Because prescription drugs are safe and effective when used properly and are broadly marketed to the public, the notion that they are also harmful and addictive when abused can be difficult to convey. Using assessment questions to gauge opioid involvement, reviewing appropriate clinical options, and engaging EAP clients through the treatment spectrum can heighten interventions aimed at preventing individuals from progressing from misuse and abuse to addiction or even overdose.

Finding a Role for EAPs in Reducing Opioid Abuse

More than 70 percent of employers in the U.S. are feeling the direct impact of prescription drug misuse in their workplaces, and many recognize that impaired workers are a concern for safety and liability, according to a recent survey (National Safety Council, 2017). To help employers and unions address this latest upsurge in drug abuse, EAPs can partner with management, unions, human resources, safety, and medical/disability management to promote employee and organizational well-being by increasing educational efforts to offer increased education and enhancing services. Some examples include:

- Promote awareness of the dangers associated with opioids and pain medications to workers, their families, and workplace managers;
- Educate workers and their families on safe storage and disposal of prescription drugs.

- Target workers in industries or job functions at higher risk of musculoskeletal disorders with specific outreach messages regarding risks of opioid pain medication abuse and use of alternative pain relief approaches.
- Offer information and consultation for management and other stakeholders, including training in observational skills to maintain a safe, impairment-free workplace.
- Encourage referrals to EAPs or other resources with a preventive and disability focus rather than a punitive approach.
- Collaborate with benefits staff, health insurers, and disability managers to advocate for coverage of and access to appropriate medication-assisted addiction treatment, prescription drug monitoring procedures to promote safe utilization, and network providers that offer alternative pain management.
- Increase assessment and diagnostic opportunities by routinely asking clients about chronic pain, use of pain medications and experiences with illicit substances, while recognizing there may be distinct differences in clinical profiles, substance-using risk behavior, and even treatment. Many common substance abuse assessment tools have not been validated in individuals with chronic pain, thus adding additional queries on this subject may increase client disclosures.
- Use motivational counseling to encourage clients to examine high-risk opioid use and opt for treatment when indicated.
- Remain engaged with clients as they enter addiction treatment, during treatment, through post-treatment and return to work transitions – to provide critical support and increase positive outcomes.
- When appropriate, coordinate EAP contacts with periodic and random urine drug screening programs, to offer additional support to those in recovery. *

Summary

EAPs are frequently at both the forefront and the nexus of efforts to assist with workplace substance abuse and treatment of employees with substance use disorders. Some have questioned the use of the term "crisis" when referring to today's increase in opioid abuse and addiction. However, the mounting toll in lives, family suffering and workplace productivity which can be attributed to opioid use and related negative health consequences cannot be ignored. As EA professionals, we have a unique and important role in responding to the needs of employees, union members, and families struggling with these conditions.

***Note:** Effective October 1, 2017, the U.S. Department of Transportation and Health and Department of Health and Human Services proposed revision of the Mandatory Guidelines for Federal Workplace Urine Drug Testing Programs will take effect, expanding workplace testing for the Schedule II opioids hydrocodone, hydromorphone, oxycodone, and oxymorphone for covered safety-sensitive positions. U.S. Federal agencies will also add these substances to drug-free workplace employee testing programs. If past practices are any indication, many employers with similar programs are likely to follow suit (Substance Abuse and Mental Health Services Administration, 2017.)

Bernie McCann, PhD, CEAP, is an independent EAP researcher, a published author in peer-reviewed journals, books and trade publications, with over 20 years of experience in EAP consultation and program management. He can be reached at mccannbag@gmail.com.

References

American Society of Addiction Medicine. (2013). FDA Approved Medications for the Treatment of Opiate Dependence: Literature Reviews on Effectiveness and Cost-Effectiveness. Chevy Chase, MD: American Society of Addiction Medicine. Retrieved from www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final.

Centers for Disease Control and Prevention (2013). Prescription painkiller overdoses: A growing epidemic, especially among women. Atlanta, GA: Centers for Disease Control and Prevention. Retrieved from www.cdc.gov/vitalsigns/prescriptionpainkilleroverdoses/index.html

Centers for Disease Control and Prevention (2017) National Center for Health Statistics, National Vital Statistics System, Mortality. Drug Overdose Deaths in the United States, 1999–2015. NCHS Data Brief No. 273 Feb 2017. Retrieved from https://www.cdc.gov/nchs/products/databriefs/db273.htm

Cicero TJ, Ellis MS, Surratt HL, Kurtz SP. (2014) The changing face of heroin use in the United States: a retrospective analysis of the past fifty years. JAMA Psychiatry.71:821–6. doi:10.1001/jamapsychiatry.2014.366

Degenhardt L, Whiteford HA, Ferrari AJ, Baxter AJ, Charlson FJ, Hall WD, Freedman G. (2013). Global burden of disease attributable to illicit drug use and dependence: Findings from the Global Burden of Disease study. *The Lancet*, 382(9904): 1564-74. doi:10.1016/S0140-6736(13)61530-5.

Kolodny A, Courtwright DT, Hwang CS, Kreiner P, Eadie JL, Clark TW, Alexander GC. (2015). The prescription opioid and heroin crisis: A public health approach to an epidemic of addiction. Annual Review of Public Health, 36: 559-574. doi:10.1146/annurev-publhealth-931914-122957.

Hughes, A., Williams, MR & Lipari RN, Bose J, Copello EA, Kroutil LA. (2016). Prescription drug use and misuse in the United States: Results from the 2015 National Survey of Drug Use and Health. Retrieved from www.samhsa.gov/data/sites/default/files/NSDUH-FFR2-2015/NSDUH-FFR2-2015.htm.

International Foundation of Employees Benefit Plans (2016) Mental Health and Substance Abuse Benefits, 2016 Survey Results. Brookfield, WI. International Foundation of Employees Benefit Plans. Retrieved from www.ifebp.org/bookstore/mental-health-and-substance-abuse-benefits-2016-survey-results/Pages/mental-health-and-substance-abuse-benefits-2016-survey-results.aspx

Jones CM. (2013) Heroin use and heroin use risk behaviors among nonmedical users of prescription opioid pain relievers - United States, 2002-2004 and 2008-2010. Drug and Alcohol Dependence. 132(1-2):95- 100. doi:10.1016/j.drugalcdep.2013.01.007.

Jamison, RN, Serraillier, J & Michna, E. (2011). Assessment and treatment of abuse risk in opioid prescribing for chronic pain. Pain Research & Treatment. Vol. 2011, Art. ID 941808, 12 pages, doi:10.1155/2011/941808.

National Institute on Drug Abuse (2016). Effective Treatments for Opioid Addiction. Retrieved from www.drugabuse.gov/effective-treatments-opioid-addiction-0

National Safety Council (2017). Adding up the impact – The real costs of substance in your workplace. Retrieved from www.nsc.org/forms/substance-use-employer-calculator/index.aspx

Perkins E & Lisa Shannon L. (2016) Understanding differences Between heroin and other drug users among individuals entering treatment. Journal of Social Work Practice in the Addictions, 16:3:306-320, doi:10.1080/1533256X.2016.1200056.

Quello, S., Brady, K. & Sonne, S. (2005). Mood disorders and substance use disorder: A complex comorbidity. *Science and Practice Perspectives*. 3(1): 13-21. Retrieved from www.ncbi.nlm.nih.gov/pmc/articles/PMC2851027/

Substance Abuse and Mental Health Services Administration. US Dept. of Health and Human Services. January 23, 2017. Revised Mandatory Guidelines by the Secretary of Health and Human Services, Retrieved from www.federalregister.gov/documents/2017/01/23/2017-00979/mandatory-guidelines-for-federal-workplace-drug-testing-programs

United Nations Office on Drugs and Crime. (2013) Opioid Overdose: Preventing and Reducing Opioid Overdose Mortality. United Nations. New York. Retrieved from www.unodc.org/docs/treatment/overdose.pdf