Final version published as: Cheng, Tessa; Debeck, Kora. Between a rock and a hard place: Prescription opioid restrictions in the time of fentanyl and other street drug adulterants. Can J Public Health, [S.l.], v. 108, n. 3, p. e325-e327, Sep. 2017.

BETWEEN A ROCK AND A HARD PLACE: PRESCRIPTION OPIOID RESTRICTIONS IN THE TIME OF FENTANYL AND OTHER STREET DRUG ADULTERANTS

Tessa Cheng, MPP,[1,2,] Kora DeBeck, MPP, PhD[1,3]

1. British Columbia Centre for Excellence in HIV/AIDS, Vancouver, Canada
2. Faculty of Health Sciences, Simon Fraser University, Burnaby, Canada
3. School of Public Policy, Simon Fraser University, Burnaby, Canada

Send correspondence to: Tessa Cheng, MPP
PhD Candidate, Simon Fraser University
Research Associate, Urban Health Research Initiative
B.C. Centre for Excellence in HIV/AIDS
St. Paul's Hospital
608-1081 Burrard Street, Vancouver, B.C.,
V6Z 1Y6
Canada

Tel: (604) 806-9142
Fax: (604) 806-9044
Email: tcheng@cfenet.ubc.ca

Type of submission: Commentary
Running title (33 characters): Opioid prescriptions and Fentanyl
Word count abstract: 96
Word count text: 1,111
References: 15
Tables: 0
Figures: 0
Conflict of Interest: None to declare

Abstract

Nonmedical prescription opioid use (NMPOU) has increased alarmingly across Canada and resulted in strict prescribing restrictions on opioids. Despite a clear need to reduce opioid prescriptions in response to this crisis, few other policies have been implemented and this singular focus is incongruent with the known characteristics of substance use disorders, negative effects of supply reduction policies, and realities of pain management. Given the recent rise of Fentanyl and other dangerous adulterants in street drugs, this commentary argues that a comprehensive response to NMPOU that includes improvements to addiction management and harm-reduction services is urgently needed.

MeSH keywords: Public health; pain; opioid-related disorder; harm reduction

Text

Nonmedical prescription opioid use (NMPOU) has created widespread public health problems across North America, as well as challenges for physicians and policy-makers alike. Recommendations for addressing NMPOU have focused primarily on restricting opioid prescribing to reduce iatrogenic dependency, NMPOU incidence, and prescription opioid (PO) diversion;[1, 2] however, broader policies to prevent and reduce the harms of NMPOU are lacking. Despite the clear need to reduce opioid prescribing, the singular focus of this response is incongruent with the known characteristics of

substance use disorders, negative effects of supply reduction policies, and realities of pain management. While safe prescribing practices that reduce PO diversion and NMPOU incidence should be promoted, the recent use of Fentanyl and other dangerous adulterants, such as Carfentanyl, in street drugs heightens the need for a comprehensive public health response that addresses substance use more widely. Consequently, we argue that it is reasonable to foresee negative consequences such as Fentanyl-related overdoses arising from constraining the supply of POs without also addressing policy deficiencies related to managing substance use disorders and pain.

A long-standing body of scientific literature characterizes problematic substance use as a chronic and relapsing neurobiological disorder[3] that is exacerbated by social and economic deprivations.[4] Despite this knowledge, stigma and misconceptions of addiction endure among some healthcare professionals which affects the quality of care for patients with substance use disorders.[5] In addition, the evidence-practice gap has resulted in morality-based law enforcement strategies that remain the predominant response to substance use and repeatedly fail to achieve meaningful progress.

Although the failing "war on drugs" has consistently demonstrated that supply reduction policies often result in perverse unintended consequences that severely undermine public health and safety, the principles of supply reduction are being expanded to opioid prescribing in numerous jurisdictions in order to prevent the

initiation of NMPOU and diversion of POs. Given the powerful withdrawal symptoms and cravings associated with opioid use disorders, however, prescribing restrictions may not have the intended effect among those who experience these symptoms and are compelled to seek out relief. Individuals who cannot acquire POs due to limited availability or cannot use POs via their preferred route of administration due to abuse deterrent formulations may resort to a substitute drug; indeed, research findings link PO supply reduction measures in the United States with transitions from POs to street drugs such as heroin among some at-risk groups.[6, 7] In an era of increasing adulteration of street drugs with Fentanyl, related analogues, and new synthetic chemicals these risks are particularly concerning.

Although POs are only effective for treating certain types of pain,[8] the issue of pain management is entwined with NMPOU given that those who engage in NMPOU frequently report pain relief as a motivation for use.[9] However, current prescribing guidelines recommend non-pharmacological therapies for treating pain which many healthcare systems are not equipped to provide or require substantial out-of-pocket expenses.[8] In addition, research on the benefits of medical cannabis is lagging despite the potential for medical cannabis to be substituted for PO use[10] and decrease PO-related emergency room admissions.[11] Consequently, sanctioned pain treatment can be very difficult to access, and this disproportionately affects at-risk groups such as older adults and those who have low incomes. This paradox is consistent with the inverse

care law, where people who are most vulnerable and in need of healthcare services are less likely to receive adequate healthcare than the general population.

Considering the well-established characteristics of substance use disorders, harms associated with supply reduction policies, and importance of effectively managing pain, the current policy focus on restricting POs is too narrow. In addition to these restrictions that reduce NMPOU incidence and PO diversion, parallel efforts to care for those already engaging in NMPOU are critical for avoiding the unintentional consequences of decreasing the supply of POs and increasing risk of exposure to adulterated street drugs. A comprehensive approach to NMPOU is needed that addresses the realities of both the NMPOU epidemic and substance use disorders, and introduces policy reforms that improve access to non-pharmacological pain treatments. These broader policy solutions may include physician-specific policies and scaling-up evidence-based harm reduction services.

To address NMPOU, physicians should use prescription drug monitoring databases and safe prescribing practices, such as urine drug screen tests and treatment agreements. Physicians who learn of patients engaging in NMPOU, however, should continue providing the best medical care for those patients instead of immediately discontinuing POs. Regimen noncompliance or NMPOU should trigger an intensification of services for these patients, which may include assistance tapering off

POs, and facilitating access to opioid agonist treatment and other harm reduction services as appropriate. Heroin-assisted treatment programs are also feasible for treating individuals who do not respond to traditional opioid agonist treatment therapies and require higher treatment intensity.[12] In addition, emergency department protocols for managing opioid withdrawal may provide an important entry point for engaging patients who use POs nonmedically in care. Although innovative solutions such as these are necessary for addressing NMPOU, novel programs or policies often lack expansive evidence bases to guide implementation in new settings. There is considerable evidence, however, affirming addiction as as chronic and relapsing medical condition that requires long-term treatment[13] and wraparound services.[14]

Efforts to reduce enduring barriers to opioid agonist treatment and expand other programs with strong evidence bases, such as drug consumption rooms, drug testing services, needle exchanges, and naloxone distribution, are also important. Despite numerous challenges to implement successfully,[15] harm reduction strategies are effective in many settings for helping people with substance use disorders maintain engagement with healthcare services, reduce potential harms such as fatal overdoses, and facilitate linkages to other services, including treatment. This approach has been successful precisely because it addresses the realities of substance use disorders without moralizing or stigma. Unfortunately, these programs are largely absent from mainstream healthcare and remain chronically under-funded as services for a relatively

small and marginalized section of the population. The ubiquity of NMPOU and the rise of Fentanyl, however, expose the need to better integrate harm reduction services within healthcare systems, expand anti-poverty programs, reduce addiction-related stigma among healthcare professionals, and give serious consideration to decriminalizing or legalizing all illicit drugs.

It is clear that physicians who prescribe and do not prescribe POs are caught in ethical dilemmas where they risk "doing harm" regardless of their decision. Despite a clear need to reduce PO prescriptions, comparable attention to closing the evidence-practice gap and implementing a comprehensive response to NMPOU beyond supply-reducing efforts is important. Given the realities of substance use disorders and emergence of Fentanyl and dangerous adulterants in street drugs , broader policy solutions will reduce the risk of pushing vulnerable citizens further to the margins and provide a meaningful response to this epidemic.

References

1. National Advisory Committee on Prescription Drug Misuse. First do no harm: Responding to Canada's prescription drug crisis. Ottawa: Canadian Centre on Substance Abuse, 2013.
2. Alexander GC FS, Gielen AC, eds. The prescription opioid epidemic: An evidence-based approach. Baltimore, Maryland: Johns Hopkins Bloomberg School of Public Health, 2015.
3. Leshner AI. Addiction is a brain disease, and it matters. Science. 1997;278(5335):45-7.

4. Rhodes T, Lilly R, Fernandez C, Giorgino E, Kemmesis UE, Ossebaard HC, et al. Risk factors associated with drug use: the importance of 'risk environment'. Drug-Educ Prev Polic. 2003;10(4):303-29.
5. van Boekel LC, Brouwers EPM, van Weeghel J, Garretsen HFL. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. Drug Alcohol Depen. 2013;131(1-2):23-35.
6. Dart RC, Surratt HL, Cicero TJ, Parrino MW, Severtson SG, Bucher-Bartelson B, et al. Trends in opioid analgesic abuse and mortality in the United States. N Engl J Med. 2015;372(3):241-8.
7. Cicero TJ, Ellis MS, Surratt HL, Kurtz SP. The changing face of heroin use in the united states: A retrospective analysis of the past 50 years. JAMA Psychiatry. 2014;71(7):821-6.
8. Guerriero F, Reid MC. New opioid prescribing guidelines released in the US: what impact will they have in the care of older patients with persistent pain? Curr Med Res Opin. 2016:1-4.
9. McCabe SE, Boyd CJ, Cranford JA, Teter CJ. Motives for Nonmedical Use of Prescription Opioids Among High School Seniors in the United States Self-treatment and Beyond. Arch Pediat Adol Med. 2009;163(8):739-44.
10. Lucas P, Walsh Z. Medical cannabis access, use, and substitution for prescription opioids and other substances: A survey of authorized medical cannabis patients. The International journal on drug policy. 2017;42:30-5.
11. Shi Y. Medical marijuana policies and hospitalizations related to marijuana and opioid pain reliever. Drug & Alcohol Dependence. 2017;173:144-50.
12. Rehm J, Gschwend P, Steffen T, Gutzwiller F, Dobler-Mikola A, Uchtenhagen A. Feasibility, safety, and efficacy of injectable heroin prescription for refractory opioid addicts: a follow-up study. Lancet. 2001;358(9291):1417-20.
13. McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness - Implications for treatment, insurance, and outcomes evaluation. Jama-J Am Med Assoc. 2000;284(13):1689-95.
14. McLellan AT, Hagan TA, Levine M, Gould F, Meyers K, Bencivengo M, et al. Supplemental social services improve outcomes in public addiction treatment. Addiction. 1998;93(10):1489-99.
15. Mancini MA, Linhorst DM, Broderick F, Bayliff S. Challenges to implementing the harm reduction approach. Journal of Social Work Practice in the Addictions. 2008;8(3):380-408.