The Scope of the Problem...

Opioid Epidemic Sweeps America

According to:
- The Center for Disease Control (CDC)
- The Surgeon General’s Office
- The Department of Health and Human Services (NIH)

...America is in the midst of an unprecedented epidemic of misuse, abuse, and overdose due to prescription pain medications, heroin and now, imported Fentanyl.

Opioids in Arkansas

- According to the CDC, as of 2017, Arkansas providers wrote 105.4 opioid prescriptions for every 100 persons. This was almost double the U.S. average of 58.7 opioid prescriptions. In 2017, there were 146 overdose deaths involving opioids in Arkansas — a rate of 0.3 deaths per 100,000 persons, compared to the national rate of 14.6 deaths per 100,000 persons (NIH, 2019).
I think if you were Satan, and you were settin’ around tryin’ to think up somethin’ that would just bring the human race to its knees what you would probably come up with is narcotics....

Maybe he did.

CORMAC MCCARTHY
No Country for Old Men
Impact of the Opioid Crisis in the U.S.

➢ In 2017, more than 47,000 Americans died as a result of an opioid overdose

➢ 130 people die each day in America of an opioid overdose

➢ That is 5.45 persons an hour...

➢ Or roughly every 13 minutes, a person dies of an opioid overdose

CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2018.

"A 22 percent decrease in opioid prescriptions nationally between 2013 and 2017 reflects the fact that physicians and other health care professionals are increasingly judicious when prescribing opioids. It is notable that every state has experienced a decrease, but this is tempered by the fact that deaths related to heroin and illicit fentanyl are increasing at a staggering rate, and deaths related to prescription opioids also continue to rise. These statistics again prove that simply decreasing prescription opioid supplies will not end the epidemic.”

Patrice A. Harris, MD, MA
Chair of the AMA Opioid Task Force

“From 1996 to 2001, Purdue conducted more than 40 national pain-management and speaker training conferences at resorts in Florida, Arizona, and California. More than 5,000 physicians, pharmacists, and nurses attended these all-expenses-paid symposia” (Van Zee, 2009)

• "A consistent feature in the promotion and marketing of OxyContin was a systematic effort to minimize the risk of addiction in the use of opioids for the treatment of chronic non-cancer-related pain" (Van Zee, 2009)

• "greater initial marketing by Purdue Pharma in non-triplicate states, leading to higher rates of prescribing which, in turn, led Purdue Pharma to target those places more in later years".

(Alpert, et al, 2019)

https://doi.org/10.2105/AJPH.2007.131714

ORIGINS OF THE OPIOID CRISIS AND ITS ENDURING IMPACTS
Abby E. Alpert, William N. Evans, Ethan M.J. Lieber, David Powell, Working Paper 26500
http://www.nber.org/papers/w26500
Seeing the whole patient

- Effective communication with patient and other healthcare staff (doctors, nurses, etc.)
- Hesitancy to ask questions about opioid use
- Hesitancy to ask about mental health concerns
- In-depth interviews
- Use of Prescription Drug Monitoring Programs
- Consider non-verbals

How nurses can help

- There are more than 3.4 million nurses across the country and having them have knowledge and insight and ability to treat patients with substance use can make a very big impact, because substance use disorder is a complex disease much like a patient has chronic diabetes.
- Having a collaborative care model where nurses work hand-in-hand with prescribers to deliver the care and to provide the concrete care management, and the day-to-day complex care such as pain, prescription issues, or getting that person access to the system when and where they need it, is critical to expanding access to treatment.
- There are more nurse practitioners actually practicing in primary care settings than there are physicians. Ensuring that nurse practitioners receive training and gain access to use medication-assisted therapy (buprenorphine) can be beneficial.

- Identify the type of Substance the person has been using, the amount, frequency, method of administration & the length of time the substance has been abused.
- Note of any Suicidal ideation or Interest, with drained Symptoms.
- Assess for level of motivation for treatment.
- Identify reason for Admission.
- A Baseline Physical & Emotional Nursing assessment is done to determine Admission status & Provide baseline from which to determine progress towards an expected Outcome.
Minimize stigma and promote an effective dialogue

• Let the patient tell their story. Start out broadly, asking open-ended questions to get the patient talking about their story—not their substance use disorder story, but rather their personal story.

Minimize stigma and promote an effective dialogue

• Get to the heart of the matter. Understanding the reason for a patient’s substance use is key to finding the treatment option most suitable for that patient. For example, is it related to an underlying condition such as PTSD? Convey respect. Stigma is a big issue in these conversations, and respect is a key ingredient to avoiding it. People with SUDs are used to being treated poorly by others.

Minimize stigma and promote an effective dialogue

• Never conduct the interview while standing. Try to sit at the same level as the patient.
• Make eye contact.
• Say things that are encouraging, empathetic and simple during their story, such as, “that sounds really difficult” (AMA, 2016).
SAMHSA'S KEY PRINCIPLES OF A TRAUMA-INFORMED APPROACH

Neurochemistry of Addiction

Addiction as a Brain Response to Trauma

- Traumatized people have repeatedly been noted to have an all or nothing response to emotional stimuli. They have an impaired capacity to modulate the intensity of their emotional responses by anxiety, anger, or intimacy.

Their entire world is a trigger
This is your brain on trauma

Screeners that can be incorporated into care

Drug Screening Questionnaire (DAST)

Which of the following drugs have you used in the past year?

- alcohol
- barbiturates (speed, crystal)
- hallucinogens
- inhalants (cigarette, aerosol, glue)
- hypnotics (rohypnol)

How often have you used these drugs?

- Monthly or less
- Weekly
- Daily or seven days a week

1. Have you tried drugs other than those listed for medical reasons?
   - No
   - Yes

2. Do you abuse more than one drug at a time?
   - No
   - Yes

3. Are you乏力 when using drugs when you were not?
   - No
   - Yes

4. Have you ever lost control or stopped in a result of drug use?
   - No
   - Yes

5. Do you ever feel bad or guilty about your drug use?
   - No
   - Yes
Empathy

• The number one predictor of success in therapy. There is a direct relationship.
• As empathy goes up so does the rate of success.
• Empathy is not sympathy.

What is Motivational Interviewing

• A directive, client-centered counseling style.
• It elicits behavior change by helping clients explore and resolve ambivalence.
• It helps resolve ambivalence by increasing discrepancy between client's current behaviors and desired goals while minimizing resistance.
• During MI empathic listening is essential to minimizing resistance.
• A way of being with people, characterized by:
  • Collaboration (vs. one-up, authoritarian relationship)
  • Evocation (vs. imparting or inserting knowledge)
  • Autonomy-supportive (vs. controlling) (Leffingwell)
### Stages of Change – Prochaska and DiClemente

<table>
<thead>
<tr>
<th>Stage</th>
<th>Client Response</th>
<th>Counselor Task</th>
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</thead>
<tbody>
<tr>
<td>1 - Precontemplation</td>
<td>No problem or need to make change</td>
<td>Raise doubt and provide information to increase client’s perception of risks and problems with current behavior</td>
</tr>
<tr>
<td>2 - Contemplation</td>
<td>Considers change</td>
<td>Tip the balance, evoke questions to change, risks of not changing</td>
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<tr>
<td>3 - Determination or Preparation</td>
<td>Window of opportunity when client seriously considers change and makes a commitment to action</td>
<td>Help client determine the best course of action.</td>
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<tr>
<td>4 - Action</td>
<td>A particular action to solve or change the problem and begins to implement the action or plan</td>
<td>Help client take steps toward change</td>
</tr>
<tr>
<td>5 - Maintenance</td>
<td>Develops new behaviors to maintain change</td>
<td>Help client identify and use strategies to prevent relapse</td>
</tr>
<tr>
<td>6 - Relapse</td>
<td>Normal, expected but encouraged to start again.</td>
<td>Help client renew process of contemplation, and action w/o becoming “stuck” or demoralized because of relapse.</td>
</tr>
</tbody>
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### Transtheoretical Model: Stages of Change

Clients may move into recurrence from action or maintenance, then back into any other stage of change.
Five General Clinical Principles of Motivational Interviewing

- Express Empathy – Accurate Empathy
- Develop Discrepancy
- Avoid Argumentation
- Roll with Resistance
- Support Self Efficacy

- Acceptance and respect. Utilize reflective listening
- Create and amplify, in the client’s mind, a discrepancy between present behavior and broader goals
- Resistance is affected by how the counselor responds
- Reluctance and ambivalence are not opposed, but acknowledged to be natural.
- Belief in the possibility of change.

Simple reflection

- The simplest approach to responding to resistance is with nonresistance, by repeating the client’s statement in a neutral form. This acknowledges and validates what the client has said and can elicit an opposite response.
  - Client: I don’t plan to quit drinking anytime soon.
  - Clinician: You don’t think that abstinence would work for you now.

Reflective Listening

- Client: What do you mean by “abstinence”?
  - Clinician: I mean total abstention from alcohol.
- Client: I see what you mean. But then I wonder why can’t I just have a drink now and then?
  - Clinician: You think it might help?
- Client: It’s not like I’m really serious, but sometimes I feel I can’t think straight most of the morning.
  - Clinician: It messes up your thinking, your concentration.
- Client: Yes, and sometimes I have trouble remembering things.
  - Clinician: And you wonder if that might be because you’re drinking too much?
- Client: Yes, I think it might be sometimes.
  - Clinician: You’re pretty sure about that. But maybe there’s more...
Reflective Listening

Client: Yeah, even when I’m not drinking, sometimes I mix things up, and I wonder about that.

Clinician: Wonder if...?

Client: If alcohol's pickling my brain, I guess.

Clinician: You think that can happen to people, maybe to you.

Client: Well, can’t it? I've heard that alcohol kills brain cells.

Clinician: Um-hmm. I can see why that would worry you.

Client: But I don’t think I’m an alcoholic or anything.

Clinician: You don’t think you’re that bad off, but you do wonder if maybe you’re overdoing it and damaging yourself in the process.

Client: Yeah.

Clinician: Kind of a scary thought. What else worries you?

References


