THE OPIOID CRISIS OF 2017: 8,000 YEARS IN THE MAKING!
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Proposition #1

The opioid crisis represents one of the greatest opportunities for the chiropractic profession in terms of public health, reduction of human suffering and, response to societal need.
Proposition #2

The opioid crisis holds the greatest potential for united action on the part of the profession in our history.

God’s Own Medicine—Sir William Osler

- The Greek god of Hypnos and the Roman god of Somnos are often depicted carrying or wearing poppies.
- Opium use spread by the 8th century A.D. to Arabia, India, and China—its use was popular because The Prophet Mohammed had prohibited alcohol but not hashish or opiates.
- Turkish and Islamic cultures amplified the effect by smoking opium.
- Referred to over the years as the “Sacred Anchor of Life”, “the Hand of God” and “Destroyer of Grief”.

“World’s 1st Authentic Anti-depressant”

- Opium doesn’t impair the senses, the intellect, motor coordination or sensory perception like alcohol.
- Pain becomes “less threatening, intrusive and distressing; but it can still be sensed and avoided”.
- Opium was treated as a social drug and opium smoking helped achieve a sense of conviviality.
How Did the Joy and Happiness become Addiction and Death?

■ In the 16th century the freebase form of opium was extracted into brandy essentially producing tincture of morphine and known then as laudanum – “something to be praised”

■ Laudanum was standardized as a formulation of “2 ounces of opium, 1 ounce of saffron: a drachm (an 1/8th of an ounce) of cinnamon and cloves—all dissolved in a pint of Canary wine”

■ By the 17th century opium was being eaten in India, smoked in Turkey, mixed with tobacco and smoked in China

■ By the late 1700s the British East India Company controlled the prime Indian poppy growing area near the Ganges

■ In 1839 Tao Kwang, Emperor of China banned the use and importation of opium. He sought the support of Queen Victoria. It was not provided. The First Opium War began

■ In 1856 the Second Opium War began

The British East India Company shipped opium to China, where it traded it for tea.
- By the 19th century the habit forming Laudanum was widely available in English pharmacies and groceries. From 1830 to 1860 opium imports to Britain increased from 91,000 pounds to 280,000 pounds.
- Opium based preparations were commonly provided to children as a “dependable way to keep their kids happy and docile.”
- In this period opium was common medicine to which one could not become addicted.

- In the U.S. poppy production was common from Revolutionary days forward.
- The Civil War caused a dramatic uptick in morphine use at a time when it was perceived to be non-addictive.
- This was accompanied by a wave of fashion that saw injectable drugs as being in vogue in high society.
- The Chinese immigration of the 1800s brought a new opium-experienced population to the U.S.
The high society version of the “opium den” in contrast to the often pictured Chinese opium and its associated negative connotations.

- In the 1890s the first attempts to limit opium use in the U.S. were implemented to confine opium use to opium dens.
- In 1914 The Harrison Act caused sellers to register and implemented taxation of opium.
- In 1924 The Heroin Act outlawed all things heroin.
- In 1951 The Boggs Act began to increase prison terms for drug related activities.
- In 1970s The Controlled Substances Act established the Five Schedule drug system.

Opium ➔ Non-addictive ➔ The Fix ➔ Diacetylmorphine aka Heroin ➔ Far less addictive ➔ Oxycontin ➔ Non-addictive

Pain: The “Fifth Vital Sign”

- Recommendation: make pain assessment/management a priority in daily practice.
- Consider pain intensity the fifth vital sign: measure along with temperature, pulse, respiration, and BP.
- Patients’ rights: full pain work-up when pain is not easily characterized or treated.

“the Joint Commission published a book in 2000 for purchase by doctors as part of required continuing education seminars, and that the book cited studies claiming "there is no evidence that addiction is a significant issue when persons are given opioids for pain control."

Author(s): Brian F. Mandell, MD, PhD


In 1996, Purdue Pharmaceuticals released a new opiate, Oxycontin, onto the market with FDA approval. There was no evidence the new formulation worked any better than off-patent older opiates. It was simply packaged in a time-release formulation.


Oxycontin was directly marketed to doctors whose narcotic prescription patterns had been studied, and they were known to be opiate over-prescribers. Primary care physicians were encouraged to prescribe Oxycontin liberally for chronic pain of all kinds. Oxycontin was deliberately and falsely presented as having a low risk of addiction—it was alleged to be the answer to oxycodone abuse!

Overdose deaths involving prescription opioids have quadrupled since 1999, as have sales of these prescription drugs. From 1999 to 2014, more than 165,000 people — three times the U.S. military deaths during the twenty years of the Vietnam War — have died in the U.S. from overdoses related to prescription opioids.


At least half of all U.S. opioid overdose deaths involve a prescribed opioid. In 2014, more than 14,000 people died from overdoses involving these drugs, with the most commonly overdosed opioids — Methadone, Oxycodone (such as OxyContin®), and Hydrocodone (such as Vicodin®) — resulting in death. Regrettably, overdose deaths resulting from opioid abuse have risen sharply in every county of every state across the country, reaching a new peak in 2014: 28,647 people, or 78 people per day — more than three people per hour.


- As much as 3 to 4 percent of the adult U.S. population is prescribed long-term opioid therapy, and there are nearly 19,000 prescription opioid poisoning deaths annually.
- In 2016 it was reported that a person dies from prescription opioid poisoning every 29 minutes. Annual opioid sales are enough to keep every American on opioids around the clock for 1 month.
On July 31, 2017 the White House Commission on Combating Drug Addiction and the Opioid Crisis called for the declaration of a “national emergency under either the Public Health Service Act or the Stafford Act.”

The Commission advised: “With approximately 142 Americans dying every day, America is enduring a death toll equal to September 11th every three weeks.”

Three deaths every 30 minutes...

To further put this American crisis within everyone’s grasp, consider that opioids are now the #1 killer of men under 50 years of age and they are causing more deaths in the United States than motor vehicle accidents. Characterized as the Food and Drug Administration’s (FDA) “biggest crisis” and viewed by the Centers for Disease Control and Prevention (CDC) as “the worst drug overdose epidemic in U.S. history.”
Abstract
The US ‘War on Drugs’ has had a profound role in reinforcing racial hierarchies. Although Black Americans are no more likely than Whites to use illicit drugs, they are 6–10 times more likely to be incarcerated for drug offenses. Meanwhile, a very different system for responding to the drug use of Whites has emerged...White opioids—the synthetic opiates such as OxyContin® in connection with epidemic prescription medication abuse among White, suburban and rural Americans and Suboxone® that came on the market as an addiction treatment in the 2000s – to show how American drug policy is racialized, using the lesser known lens of decriminalized White drugs.

- While over the past 15 years increasing numbers of patients have been using long-term opioid therapy, there has not been a decrease in Americans' complaints of pain. Recognizing that an opioid prescription does not equate with feeling better in the long run has been difficult for patients and clinicians alike. For these reasons, alternative non-pharmacological treatments—which take time to implement and focus on long-term improvements—remain largely on the sidelines, unavailable to patients and undervalued by health care practitioners and insurance providers.

"The opioid lobby has been doing everything it can to preserve the status quo of aggressive prescribing. They are reaping enormous profits from aggressive prescribing."

- Andrew Kolodny, MD, founder, Physicians for Responsible Opioid Prescribing

Opioids and the American Family

- The impact of the opioid crisis on American families is staggering. Nationally, an increase of children in foster care of 8% has been experienced between 2012 and 2015, with some states reporting a 25% increase in foster care placed children due almost exclusively to the opioid epidemic. Ohio’s Ashtabula County saw a quadrupling of foster care children from 2014-2016, specifically related to opioid abuse. At the same time, the federal funding to support foster care fell by 2% in 2016 dollars. Childhood is where the cycle starts to repeat, as the CDC has linked addiction to childhood stressors and subsequent addiction, more strongly than obesity is related to diabetes.

The newest estimates on the cost of opioid abuse to U.S. employers is estimated at $18 billion in sick days, lost productivity and medical expenses. Employers are paying for one-third of prescription opioids that end up being abused.


Opioid abuse is estimated to cost the American economy more than $56 billion a year.

The 2016 National Safety Council survey found:

- 99% of medical doctors prescribe highly addictive opioids and for longer than the three-day period recommended by the CDC.

The Wall Street Journal referred to America’s medical doctors as:

“the enablers of an earlier generation of American pain-pill abuse”

74 percent of doctors incorrectly believe morphine and oxycodone, both opioids, are the most effective ways to treat pain. Furthermore, the problem has reached the point where painkillers with high addictive potential, which include commonly prescribed drugs such as OxyContin, Percocet and Vicodin, now account for more drug overdose deaths than heroin and cocaine combined. 

“We do not yet understand the effects of the long term use of opioid analgesics, as no trials have followed up patients beyond 3 months. Importantly, we do know that these medicines can have significant harmful effects when used inappropriately or for longer periods of time.”


The CDC Guidelines and the National Pain Strategy share an important element to address the out of control opiate environment in the U.S.:
- encouraging medical doctors to utilize non-pharmacologic, conservative care

CDC: Non-opioid treatment for chronic pain

- “Principles of Chronic Pain Treatment
  - Evidence suggests that nonopioid treatments, including non-pharmacologic therapies can provide relief to those suffering from chronic pain, and are safer”
- “Effective approaches to chronic pain should:
  - Focus on functional goals and improvement
  - Use multimodal approaches, including interdisciplinary rehabilitation


From Samueli Institute’s Bonnie Sakarillis, Ph.D. Vice-President, Optimal Healing Environments:
- when you look at the IOM report, the FDA guidelines and the CDC guidelines, all of them recommend that non-opioid and non-pharmacologic approaches be the first approaches in dealing with chronic pain

Pains Project

- “The time is now for early integration of alternative treatment for pain relief...multiple non-pharmacological approaches, methods and practitioners with evidence to support their inclusion should be considered important tools in addressing these public health challenges”.
  

Lonnie Zeltzer, MD, director of the California-based Pediatric Pain and Palliative Care Program, advises that drugs are not the only way to address chronic pain.

- "The prevention and treatment of pain can be addressed through many different modalities, with chiropractic care being one," says Dr. Zeltzer, who is a professor of Pediatrics, Anesthesiology, Psychiatry and Biobehavioral Sciences at the David Geffen School of Medicine at UCLA. "We now know that body manipulation such as chiropractic care with a licensed, experienced chiropractor can have many physical, emotional and biologic benefits to reduce pain."

Guidelines

Other Resources
- Chronic Pain and Complementary Health Approaches: What You Need to Know (NIH National Center for Complementary and Alternative Medicine)
- Are Self-Care Complementary and Integrative Therapies Effective for Management of Chronic Pain? A Rapid Evidence Assessment of the Literature and Recommendations from the Field. (Pain Medicine, 2014)
- Clinical Update: A Holistic Model of Care (International Association for the Study of Pain, 2014)
- Clinical Update: Chronic Pain Management – Measurement-based Step-Care Solutions (International Association for the Study of Pain, 2012)
A recent study examining very large Medicare datasets found a statistically significant inverse correlation between per-capita doctor of chiropractic (DC) supply (and spending on chiropractic manipulation), and the percent of younger patients obtaining opioid prescriptions. In other words, in geographic locations with more chiropractors and a higher level of Medicare payments for chiropractic spinal manipulation, there were fewer patients taking opioid drugs.


Why should a DC get involved?

1. We are not a part of this problem or the legacy that created it.
   - "We cannot solve our problems with the same thinking we used when we created them."
     - Albert Einstein
2. Like it or not, want it or not, we have become, or allowed ourselves to become, inextricably linked to pain and in particular with spinal pain

Why should a DC get involved?

3. We represent a viable and logical solution to the problem
4. There have been calls for the non-pharmacologic care that we offer to be first lines of response from the CDC, FDA and IOM
5. We find ourselves in the unusual position of being on the societal “right” side of a major public health need
### Why should a DC get involved?

- **6.** We can save lives, untold suffering, families and fortunes
- **7.** We can use this moment to demonstrate the value of our care and the impact it has on health and well-being
- **8.** We can engage people who share our concerns about drug use, abuse and addiction
- **9.** It is the right thing to do!

### How Do I Get Involved?

- **1.** Do your homework and prep yourself with the history, facts and details that will engage the various populations you choose to reach out to.
- **2.** Adopt the right mindset. This is not a chiropractic lay lecture in disguise, this is not a new patient acquisition procedure. This is an EDUCATIONAL and INFORMATIONAL opportunity
- **3.** Understand your mission. We are not telling people what to do—we are providing information and options

### How Do I Get Involved?

- **4.** Present hard hitting facts about opiates in a straightforward, non-judgmental manner
- **5.** Provide them with common sense strategies and explain why each strategy is important:
  - *Large muscle group activity*  
  - *Eat well*
  - *Sleep well*  
  - *Be positive*
  - *Chiropractic care*
- **6.** Educate them about the reality of pain, it is a brain function first and foremost

### How Do I Get Involved?

- **7.** Be straight-forward, “Of course, as a chiropractor I think chiropractic care is important! The key, however, is that the science supports the importance of a healthy spine to having a healthy “well orchestrated” brain.”
- **8.** Stress what they can do on their own to help themselves, while gently reminding them you are there if they desire your help and guidance
What do I need to remember?

1. Be true to the literature and data. Don’t add your interpretations, let the literature stand on its own.
2. Don’t embellish. Check the data, get your numbers and quotes correct.
3. Make your presentation interesting and engaging from the perspective of your audience—not from what you think is interesting!
   - Imagine speaking to a history class about the nexus of opium, war, and regional development
   - Think about speaking to a geography class where you trace the movements of opium around the globe from society to society

4. Stress the ability to lessen suffering from addiction and the potential to avoid an opportunity for addiction to occur.
5. Don’t overload them with numbers. Use 1 in 5 of the numbers in this presentation when speaking to the general public. If they want more numbers they will ask!
6. Your goal is not new patients, your goal is the hope of one person who won’t become addicted—put them first and you will be taken care of in time.

THANK YOU FOR YOUR TIME AND ATTENTION