National American Indian & Alaska Native
ATTC Addiction Technology Transfer Center Network
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Addressing Addiction

IN OUR NATIVE AMERICAN COMMUNITIES · VOL 6 ISSUE 2 WINTER 2020

Origins of the Opioid Crisis

National American Indian & Alaska Native Addiction Technology Transfer Center
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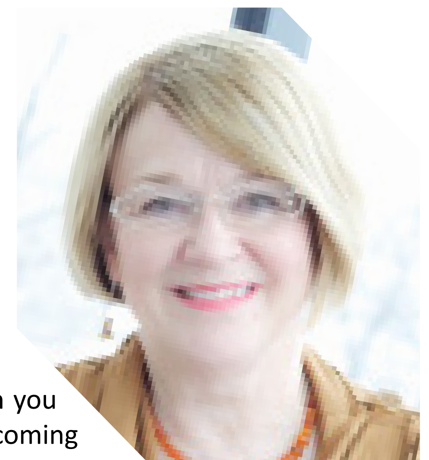
DIRECTOR'S CORNER



Welcome to our continued discussion of Opioid Use Disorders (OUD) in this edition of the American Indian & Alaska Native ATTC Newsletter. This time, we decided to go back in time to show that history tends to repeats itself; about 100 years ago, the opioid abuse in the general population was high and led to legal actions from the federal government. The main article in this issue gives an overview of some of the contributing factors and antecedents to the current opioid epidemic, and how they are similar to the epidemic 100 years ago. As professionals, we should learn from these experiences and try not to repeat them again in the future.

On an individual level, some of the antecedents to OUD are physical as well as psychological trauma. Use of opioids is often an effort to treat both physical and emotional pain; a way to self-medicate. Unfortunately, the use of opioids for self-medication without any psychosocial strategies for change in our behaviors can easily lead to OUD regardless of the origin of the pain. Therefore, the OUD epidemic is often referred to as the Disease of Despair.

Tribal and urban Indian communities have been working to support their Native community members with OUD, but often times the success stories are overshadowed by the challenges to implementation of prevention and treatment strategies. As we often say; the negative stories sell newspapers. However, the Native communities need to be reminded about all their successful efforts to reduce the opioid epidemic in their communities and for those reasons, we will continue to share how tribal and urban Indian communities together with Native providers have implemented medication-assisted treatment (MAT) and integrated traditional Native practices into their MAT and western-based treatment approaches.

Many providers have been met with negative attitudes towards implementing MAT in their treatment agencies. Furthermore, stigma against tribal members with OUD is rampant. Therefore, several communities have started MAT Anonymous groups in an effort to make sure tribal members have a mutual self-help group to support them in their recovery process. Recovery from OUD takes many forms, and one recovery path is not necessarily better than another. The main goal should be to recover from OUD. Healing to Wellness Courts are starting to consider how to integrate OUD and MAT in their programs, as well as trauma informed approaches, to assist tribal members in their recovery process.

Finally, I want to share with you some of our exciting upcoming events; first we are having our Enhancement session for the Native American Leadership Academy in Albuquerque, NM, at the end of February. Twenty-five mentors and mentees are gathering to discuss the exciting projects the mentees are developing. We are also starting the recruitment process for the fourth cohort of mentors and mentees this spring.

We have piloted the third edition of Spirit of Communication, Motivational Interviewing and Native American Teachings in California in January and we intend to roll out this training program across the country.

Non-Native providers treat many urban Indian and tribal members with substance use disorders, and some non-Native providers are not familiar with how cultural issues influence the recovery process. We have offered Native American Curriculum for Non-Native Addiction Providers in the upper Midwest for many years, and we are excited to inform you that we are in the final stages of updating this curriculum for a national audience. We anticipate that this program will be initiated in early fall.

I hope you enjoy this newsletter and check out our upcoming events, and read Sean's words of wisdom as well. We love to hear from you and get suggestions for future programing, so please reach out and share your thoughts with us.

Anne Helene Skinstad, PhD

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A Historical Perspective of the Opioid Crisis

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Introduction

As the United States continues to suffer from a public health crisis of opioid misuse, it is worth looking back at the underlying causes of the epidemic. The origins of this crisis can be traced to a perfect storm of factors: the pressure on the medical profession to seek better treatment for pain; an underestimation or under-appreciation of the addictive potential of FDA-approved pain medications; the accelerated pace of opiate prescribing; the powerful influence by medical and pharmaceutical professional bodies; the intensive marketing and large profits from the pharmaceutical industry; and exploitation by the black market. Too often, the early warnings of a health crisis were minimized or ignored by regulating authorities and governments.

Even though the rate of lethal opioid overdoses has declined recently, attributed at least in part to a drop in the number of deaths from heroin and prescription painkillers, over 60,000 Americans died of opioid overdoses in 2019.[1] The current opioid crisis now includes illicit synthetic opioids like fentanyl and carfentanil that have a dangerous risk of lethality. Native American and Alaska Native (NA/AN) people are second only to whites in the US for opioid overdose mortality,[15] and NA/AN youth have disproportionately high rates of both heroin and other opioid misuse.[22]

In our ATTC's *September 2016 National Recovery Month Issue*, we highlighted several efforts that tribes have taken to respond to the opioid epidemic. We included examples from: the Blood Tribe/Kainai First Nation, Cherokee Nation in Oklahoma, Mille Lacs Band of Ojibwe, and Lac du Flambeau community. Both the One Tribal program, funded by the Washington State Health Care Authority, and a revision of the Wisconsin program, Dose of Reality Campaign, were noted as recent opioid campaigns aimed at informing Tribal communities about the opioid crisis, including the dangers of prescription drug misuse. Subsequently, in our *Fall 2019 newsletter, The Opioid Crisis: Moving Forward*, we highlighted several noteworthy public health responses to the crisis, and how government initiatives are aimed at Native communities.

This issue's column on the opioid crisis shows a historical perspective. Understanding the history of any public health crisis can inform solutions going forward with the current crisis, and provide valuable lessons that can help health officials face future challenges.

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Additional Examples of NA/AN Communities Responding to the Opioid Crisis

White Earth Nation has trained over 100 tribal employees in how to treat overdoses, saving at least 16 lives in the past year. In addition, the nation's Maternal Outreach and Mitigation Service has already helped 48 mothers, babies, and families with addiction and recovery.

The Cook Inlet Tribal Council (CITC) Recovery Services department, one of only two detox centers in Alaska, provides detox and a comprehensive range of treatment services to about 850 individuals each year.

The Lummi Nation's Healing Spirit Opioid Treatment Program offers medication assisted treatment, counseling, and accountability through drug testing when treating opioid dependence.[8]

A Complex Path Toward the Crisis

Extracts of the poppy plant have been used for medicinal purposes throughout history. In the US, some form of opioid has been either part of medicine or culture since the American Revolution.[4,23] We've listed several defining milestone periods below:

1. In the 1800s, many became addicted to an elixir of alcohol and 10% powdered opium ("laudanum"), that was widely prescribed to treat pain and as a cough suppressant.
2. During the Civil War, morphine was isolated from opium as pain medication and led to an epidemic of addiction.
3. Heroin, marketed by Bayer Pharmaceuticals, was viewed as a safer analgesic. Continuing to the end of the 1800s, heroin was sold over the counter in "emergency kits" equipped with hypodermic syringes and needles.
4. The growing problem of opioid addiction prompted federal legislation to control it in 1906, 1909, 1914, and 1924.
5. The 1970s saw an escalation of drug use. The declaration of the "war on drugs" by the Nixon administration contributed to federally-supported methadone clinics to address the heroin addiction problem. Subsequently, methadone quickly became a drug of misuse.

The 1990s Mark the Onset

The 1990s marked the beginning of the current American epidemic of opioid-related deaths.[23] Various experts have weighed in with a systematic analysis of how the crisis developed and all of them characterize its cause as a perfect storm of multiple and interacting factors that included good intentions, greed and poor oversight. Richard D. deShazo and colleagues[6] highlighted several factors that "promoted the escalation of opioid use" in the US by the mid-1990s, including the factors identified by Nicholas B. King and colleagues in Table 1.[19]

Table 1: Key Factors Contributing to the Escalation of Opioid Use in the US[19]	
A well-intentioned effort among some physician groups to better manage chronic pain	False marketing claims about addiction to new, longer-acting opioids
Lack of physician education on the use of drugs with high abuse potentials	Direct-to-physician marketing
Provider-run pill mills	Culture of drug use and abuse
Multitude of cheap, widely available drugs of abuse including black tar heroin	Over-prescription of narcotics
Expansion of Mexican drug cartels	Corporate greed

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From Policy, to Approval, to Production

Without these four factors - policy, approval, production and promotion - the opioid crisis may never have materialized. All of them were influenced by the sympathetic view from the medical field that pain was being under-treated and that opioids were the most effective treatment for many patients.

Policy

The Controlled Substance Act of 1970 relaxed the anti-opioid portions of the Harrison Narcotics Act of 1914 and recognized that opioids had legitimate medical purposes. But several claims and position statements that began in the 1990s accelerated the movement to put opioids as a staple for pain treatment. Namely, leaders of the American Pain Society (APS) concluded that opioid maintenance therapy for chronic non-cancer pain was safe and humane. APS joined with the American Academy of Pain Medicine in 1997 to claim that the risk of addiction from opioids to treat pain was minimal. In 2001, the Joint Commission of Pain Management Standards tied accreditation and reimbursement to a hospital's requirement to assess and address pain in all hospitalized patients. By 2010, two organizations (International Association for the Study of Pain and the American Pain Foundation) advanced the pro-opioid momentum with the claim that patients were entitled to better pain management. Lastly, the 2011 Institute of Medicine report, Relieving Pain in America, provided further validation that opioids were effective and under-utilized medicine.

Approval

In the United States, the Federal Drug Administration (FDA) is responsible for overseeing drug safety, effectiveness and promotion in the marketplace. In the early 1990s, the FDA, with input from the pharmaceutical industry, implemented an "Enriched Enrollment Protocol" to speed the approval process for pain medication.[9] This protocol is believed to have resulted in increases in drug approval rates and the risk of side effects going undetected. To compound matters, the FDA was understaffed, affecting their ability to ensure that the information supplied in drug advertising and promotion was accurate and balanced.[6]

Production

In 2001, the Drug Enforcement Agency (DEA) joined with 21 health care organizations to call for improved approaches to ensure that prescription opioids were available for medical use and prevented from diversion.[27] Between 1996 and 2007, the DEA approved increases in US production of opioids several times over, yet its physician sanction rate for narcotic-prescribing violations was extremely low from 1999 to 2003 (< 0.1% of physicians were sanctioned).[13]

OxyContin®: An Example of Missteps in Oversight

Richard D. deShazo and colleagues[6] provide insights as to underlying factors that contributed to the abuse of OxyContin®. The manufacture's FDA application for approval grossly underestimated the drug's potential for abuse; the original manufacturer's label stated that addiction to the drug was "very rare." Also, the FDA can be faulted in their review of the original application by "missing the disclosure that crushing tablets immediately released 68% of the oxycodone and thus promoted it to become a drug of abuse." The 2004 label revision of OxyContin® cautioned patients not to chew or bite the tablet, which further clued abusers to crush it for illicit use.

Promotion

The pharmaceutical industry aggressively advanced marketing plans using sales forces that numbered in the hundreds who targeted lists of tens of thousands of physicians judged likely to prescribe pain medications. Many physicians received free trips to exotic locations to hear paid members of the company's "Speakers Bureau" give talks promoting opioids to treat chronic pain. In some instances, patients received coupons for a free supply of pain medications.

Addressing the Crisis

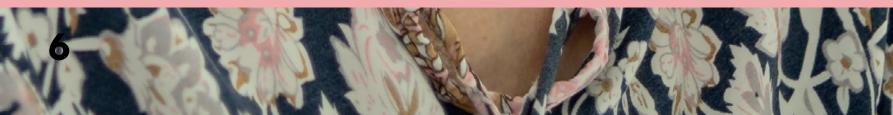
Responding to America's present opioid epidemic may benefit from lessons learned from this country's long fight to prevent tobacco use and to treat nicotine addiction. Like widespread nicotine addiction, the opioid crisis calls for multifaceted approaches that include researchers, policy makers, prevention experts, medical professionals, and the treatment community.

Research

Research is needed to address the many questions about the underlying biological mechanisms of pain, the treatment of acute and chronic pain, predictors of non-cancer pain, and the treatment of opioid addiction. The course of the epidemic to date reflects our ignorance of the neurobiology of the brain's reward system and the need for investment in basic and clinical research to understand why drugs of abuse are so alluring to many individuals.[6] The underlying assumption that opioids are safe and effective for chronic pain clearly needs to be reexamined. Also needed is a greater understanding of the impact of US state policies that limit the duration of a person's first opioid prescription following surgery or for nonsurgical acute pain.

The Role of Fentanyl in the Opioid Crisis

Pharmaceutical fentanyl is a very poweful synthetic opioid pain reliever. Fentanyl is 50 to 100 times more potent than morphine. It is approved to treat severe pain, typically associated with cancer. Fentanyl has been a source of diversion through illegal markets and produced illegally as well. Experts believe that the illegal market often mixes fentanyl with heroin or cocaine to create a highly euphoric drug mixture. Careless mixing and/or use of adulterated drugs by unwitting customers too often leads to a fatal outcome for the user.[23] Fentanyl overdoses have risen sharply in the last 5 years.[17] Compounding the problem is that the illegal production of fentanyl is significantly cheaper than the production costs of heroin.[11]



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Treating Opioid Abuse and Addiction

Those suffering from opioid addiction clearly need better access to addiction specialists and mental health services. People with opioid use disorder often suffer from a chronic illness that requires ongoing communication between patient and provider to ensure that patients can access both pharmacotherapy and psychosocial treatment and support. Many patients suffering OUD are at an elevated risk to suffer from another substance use disorder or other mental or behavior disorders.[5] It is estimated that in about 20% of cases, the patient suffers from a pre-existing, co-occurring psychiatric disorder, such as depression, anxiety, PTSD, antisocial personality disorder, or other substance use disorders (e.g., heroin addiction).

In some instances, patients may experience psychiatric symptoms only while using the opioid or when in withdrawal from it. Because these problems can stop after a period of time with no drug use, the person may not have a core, underlying co-occurring disorder. Clinically, distinguishing between these two types of "co-occurring problems" requires a detailed and accurate diagnostic assessment.

Medication-Assisted Treatment (MAT) is considered the gold standard for treating opioid addiction. MAT combines the use of medications and behavioral therapy-based counseling to provide a comprehensive treatment for the substance use disorder. Research shows that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, MAT can help sustain recovery.[26] With respect to opioid addiction, relapse is common among patients battling OUD and achieving an addiction-free lifestyle will likely require a comprehensive approach.[16] Federal law requires that Opioid Treatment Programs (OTPs) provide MAT that includes counseling, vocational services, educational services, prescribed medication, and other assessment and treatment services. OTPs seek to address the person's addiction and promote long-term recovery, as well as improving the quality of the patient's life *(SAMHSA's directory of OTPs in the US can be found at this link)*.

The link between opioid abuse and pre-existing psychiatric conditions is not unique to opioids. All substance use disorders, including nicotine addiction, have been linked to pre-existing, co-occurring disorders. The disorders common to opioids abusers are similar to those linked to all other substance use disorders.[18]

Case Example of Researching Opioid Overdose

American Indians in Minnesota have the highest opioid overdose death rate of Native Americans and Alaska Natives in the United States. This devastating problem was studied by a partnership between a Minnesota rural tribal nation, Gaa-waabaabiganikaag (White Earth Nation), and investigators at the University of Minnesota Medical School Duluth. An epidemiological study was conducted to identify risk and protective factors of opioid overdose deaths over 5 months during 2019 in the White Earth Nation community. Based on fatality records, researchers were able to identify some specific overdose risk factors:

1. hesitation or refusal to call for assistance,
2. lack of coordination with other substance use disorder treatment programs,
3. unaddressed medical and mental health needs,
4. movement between reservations and to urban areas, and
5. poor data accuracy and availability.

The results from the focus groups identified these risk factors:

1. implications of historical loss,
2. historical and contemporary trauma,
3. shame and stigma,
4. effects on children, and
5. jurisdictional issues and rurality.

Protective factors identified from the focus groups included:

1. innovative solutions,
2. availability of naloxone,
3. community collaborations, and
4. strong identity to culture.

The authors concluded that "opioid overdose death inequities among American Indians in Minnesota and the participating tribal nation have multiple contributing factors that offer an opportunity for intervention. There is a particular need for community involvement, multidisciplinary collaboration, continued naloxone outreach, additional funding for multiple services (e.g., recovery-based housing, mental health, cultural programming, and transitional [reentry] support services), and improving reliability and access of pertinent data."[12]

If a person stops taking an opioid, it is likely he or she will experience withdrawal symptoms. Early symptoms include muscle aches, restlessness and excessive sweating; later symptoms include nausea, vomiting and high blood pressure. It is critical to see your doctor as soon as possible to get treatment for this condition.

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The medication is an important component of treatment, as it helps normalize brain chemistry, blocks the euphoric effects of opioids, and reduces withdrawal symptoms and psychological cravings. Medications approved by the FDA include methadone, buprenorphine (a milder opioid), naltrexone and suboxone. Suboxone is a combination of buprenorphine and an opioid blocker (naloxone) that does not produce many of the addictive effects of other opioids. Methadone is a powerful opioid, but it can be used for long-term maintenance therapy in a controlled manner that is less likely to produce intense withdrawal symptoms. Several strategies can minimize the abuse of these medications (e.g., directly observing administration of the medication; frequent urine drug screens to ensure consumption).[23] Rigorous research is needed to establish if non-opioid medications and nonpharmacologic interventions (such as mindfulness therapy) can be effective in pain control.

It is a legitimate research question if pharmaceutically-produced compounds from the cannabis plant can be effective pain medication. The National Institute on Drug Abuse is currently funding several cannabinoid-based medication research studies. We caution readers to reserve judgment on this issue. Earlier claims that enacting marijuana laws may ameliorate the opioid abuse crisis have proven to be premature.[3] More rigorous studies suggest that the opioid abuse does not improve after enacting pro-marijuana laws.[14,25]

Naloxone (also known as Narcan®) is an "opioid antagonist" that counters the effects of an overdose from an opioid. It works by counteracting the life-threatening depression of the central nervous system and respiratory system, thus allowing a person to breathe again. Naloxone can be administered by minimally trained laypeople (there is a version that can be sprayed into the nose), which makes it ideal for treating overdose in people in diverse settings.

Regulations and Prevention

Governmental regulatory agencies and specialty-specific physician associations have released multiple regulatory measures and societal recommendations that have helped reduce the amount of opioid prescriptions over recent years. Several harm reduction approaches have been taken across the US:

1. with some success, prescription drug monitoring programs are being used to identify patients who obtain several prescriptions for opioids at the same time;[10]
2. numerous states are requiring educational programs for health care providers;[2] and
3. in 2018, public and private insurers began to limit payments, based on the amount of daily morphine equivalents in opioid prescriptions.

These approaches may be exerting their influence: the number of opioid prescriptions written per 100 persons has recently fallen,[7,10] and since early 2018, there is a decline in the incidence of opioid overdose deaths.[24]

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The pharmaceutical industry's role in exacerbating the opioid crisis in the US has led to a spate of lawsuits. In late 2019, Purdue Pharma, the maker of the opioid drug OxyContin®, reached a tentative deal worth billions of dollars to resolve thousands of lawsuits brought by some 2,600 local governments across 24 states. That tentative deal has not been finalized, as some states oppose it. Also, more than a dozen other drug makers, distributors, and pharmacy chains could face an upcoming federal opioid trial which may be considered as a test case for establishing the pharmaceutical industry's liability.[20,21]

Concluding Remarks

Addressing this opioid epidemic will require a multidisciplinary approach, along with continuing efforts from physicians, legislators, pharmaceutical companies, educators, and the general public.[6] It is hoped that in the long term, a decrease in opioid dispensing, greater public awareness, and improved monitoring by the medical profession will reduce exposure to these highly addictive drugs and stop opioid-related deaths, as well as prevent an epidemic of this magnitude from happening again.

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RECENT ACTIVITIES & UPCOMING EVENTS

Date	Event	Location
01/08	ESAS webinar: Referral, Service Coordination, and Documentation	View the recording
01/13-14	Spirit of Communication: Motivational Interviewing training	McKinleyville, CA
01/21-23	ORN Opioid Prevention Thought Leader Meeting: Strategies Used by the Prevention Workforce	Phoenix, AZ
02/05	ESAS webinar: Basic Counseling Skills	View the recording
02/19	Behavioral Health webinar: Practicing Self-Care in the Helping Professions	View the recording
02/22-23	Ho-Chunk Nation Spiritual Gathering of Healers - *Staff will attend this gathering*	Black River Falls, WI
02/26-28	Leadership Academy: Enhancement Session	Albuquerque, NM
02/26-28	Regional TOR TA Meeting	Oklahoma City, OK
03/04	ESAS webinar: Group Counseling	Online - register
03/17	National Indian Health Board's Tribal Public Health Summit Pre-Summit Institute: Healing the Returning Warrior	Omaha, NE
03/19-20	Spiritual Round Table *(dates are tentative)*	Denver, CO
03/24-26	Great Plains Behavioral Health Director's Meeting	Council Bluffs, IA
03/31-04/1	Spirit of Communication: Motivational Interviewing training	TBA
04/01	ESAS webinar: Counseling Families, Partners, and Significant Others	Online - register
04/21-23	Regional TOR TA Meeting	Asheville, NC
04/31	TOR Grantee Summit	Anchorage, AK

For additional events in our Mental Health and Prevention programs, please visit their websites:
MHTTC: mhttcnetwork.org/native; PTTC: pttcnetwork.org/native

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To let go of pain is to free yourself of it

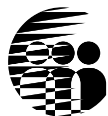
There are teachings that tell us that in order to be healed, you must believe in the healing. Other teachings tell us that one does not need to have these beliefs in order to heal. You must be willing, though, to let go of the things that may play a part in the pain.

Take for instance emotional pain; most of us have been through something in our past that hurt us greatly. While experiencing this pain, we may have cried, even when we did not want to, or could not concentrate on anything. Relationships for example, bring about an emotional element that if affected, can hurt us very much.

This emotional pain that we may have feared, tried to avoid, or fought hard not to think of, ends up being stuffed down so we don't have to deal with it. Some of us end up holding on to this pain within us. It hardens like a shield so that no one will ever hurt us like that again. We may end up not crying when we don't want to, but in some ways we may appear cold.

In order to heal this pain one feels, we must be willing to let it go, even though we may fear letting go of something that has protected us for so long.

Sean A. Bear 1st, BA
Co Director, Meskwaki Tribal Member



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