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Management of Chronic Pain: What Employees and Employers Need to Know about Treatment with Opioids

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Background: The Problem

An iatrogenic disability is one that originates with, or is induced by, medical treatment. For example, opioid dependence or addiction (the National Institute on Drug Abuse defines addiction as a "chronic, relapsing brain disease") can be induced by physician prescription when the medications prescribed are not properly used and monitored. Opioids, or "painkillers," are synthetic narcotics with chemical properties similar to opium prescribed to relieve pain and include morphine (for severe pain) and codeine (for milder pain). OxyContin, Percocet, and Vicodin are common brand names of opioid medications, and when taken exactly as prescribed, they can effectively treat pain symptoms. However, these medications are frequently abused, causing dependence and an increasing number of deaths due to overdose. In fact, the Centers for Disease Control and Prevention (CDC) describe the prevalence of overdoses on prescription painkillers as a "public health epidemic" in the United States. The CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA) report some alarming statistics:

- In 2010, 12 million Americans (age 12 or older) reported nonmedical use of prescription painkillers in the past year.
- The highest rates of nonmedical use are among young adults (ages 18 to 25).
- Nearly 15,000 people die every year due to overdosing on prescription painkillers.
- Between 1999 and 2010, painkiller prescriptions increased by 300%.

The New England Journal of Medicine (NEJM) also reports on the prescription

opioid abuse epidemic, noting that 60 percent of abused opioids are obtained directly through a physician's prescription and that in many instances, "doctors are fully aware that their patients are abusing these medications or diverting them to others for nonmedical use, but prescribe them anyway." If they are indeed aware of the often-disastrous effects of painkillers, why are doctors still prescribing them?

Recent trends in our attitudes towards suffering and pain, as well as financial incentives or disincentives, are largely contributing to the continuing prescription patterns. Throughout the 19th century, doctors viewed pain as a good thing – it was "a sign of physical vitality and important to the healing process," according to Anna Lembke, M.D., writing for the NEJM. Over the past 100 years, however, there has been a paradigm shift: "Today, treating pain is every doctor's mandated responsibility." Dr. Lembke sites specific legislation and notes, "In contemporary medical culture, self-reports of pain are above question, and the treatment of pain is held up as the holy grail of compassionate medical care."

Unfortunately, prescribing opioid medications for treatment of chronic pain is quicker and cheaper than implementing multidisciplinary approaches to pain management. Additionally, in a society that recognizes a patient's fundamental right to pain control, physicians may be further discouraged from refusing to prescribe opioids in favor of nonmedical treatment options. Disincentives for nonmedical treatment can include fear of litigation for failing to treat/under-treating pain and loss of patients and hospital privileges, according to the American College of Preventive Medicine. Healthcare organizations along with the Drug Enforcement Administration have advised healthcare professionals of the "critical balancing act" of managing pain effectively and aggressively while preventing the misuse and abuse of prescription medications.

The medical community, however, seems to be recognizing that opioid medication is not the cure-all for treatment of chronic pain. In June 2011, the Institute of Medicine (IOM) issued a report on the cost of chronic pain, "Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research." The IOM listed several underlying principles that informed its approach to the report, including:

- the committee recognized the serious problem of diversion (the intentional removal of a medication from legitimate and dispensing channels), abuse of opioid drugs, and questions about their long-term usefulness;
- pain results from a combination of biologic, psychological, and social factors and often requires comprehensive approaches to prevention and management; and
- chronic pain has such severe impacts on all aspects of a person's life that every effort should be made to achieve both primary prevention and secondary prevention through early intervention.

The IOM aptly notes that chronic pain severely affects *all aspects* of a person's life, and that certainly includes a person's work. Organizations such as SAMHSA and the National Business Group on Health are addressing the significant effects of substance abuse, and more specifically prescription drug abuse, on the health and safety of workplaces, as well as its significant costs for employers in expenditures for health care, workplace injuries, disability payments, and productivity losses.

Opioids' Shortcomings in the Treatment of Chronic Pain

The goal of opioid therapy is to reduce pain perception to the brain, and thus alleviate the patient's pain and improve his or her function. Because chronic pain is indeed persistent, rather than acute or short term, a person with chronic pain seeks relief over a longer period. However, because organisms build a tolerance to the effects of narcotics, the effective dose must increase over time.

Moreover, the analgesic effect of each dose is time-limited to approximately three to four hours. Consequently, one is left to take more and more of the chemical to experience the desired therapeutic effect throughout the day as the body and mind gradually learn to need increasing amounts of the chemical for both pain relief and homeostasis. Meanwhile, the individual with chronic pain becomes dependent on the temporary relief of the opioid compound and its side effects, which include hormonal changes causing depression and reduced energy; hyperalgesia, or increased pain sensitivity; sedation and drowsiness; and sleep disturbances. These stuporous effects engender passivity and reduce the pain patient's ability to take an active part in managing his or her chronic pain. In other words, treating chronic pain primarily or exclusively with morphine and/or similar compounds postpones, or even eliminates, the necessary effort individuals must carry out to cope with chronic pain.

In her book, "Managing Pain Before it Manages You," Dr. Margaret Caudill, an internist and instructor of anesthesiology at the Dartmouth Medical School, encourages chronic pain patients to accept ownership of their pain and learn coping skills to recapture their lives. However, Dr. Caudill recognizes that this self-ownership can be a challenge for pain patients, as a significant contribution to the reinforcement of chronic pain is "learned helplessness." What we have described elsewhere as injured worker helplessness is the loss of motivation and subsequent inactivity due to an individual's perceived uncontrollability, often post-injury, and in the context of personal injury litigation, workers' compensation claims, and even within one's family. Moreover, it is easy to imagine how the physiological and psychological side effects of opioid use, as well as the effects of opioid dependence, addiction, and withdrawal, can compound the loss of control and acquiring of helplessness in the chronic pain patient.

Dr. Caudill and numerous other healthcare providers and organizations recognize that opioid treatment in chronic pain will not free the patient from chronic pain. Additionally, proper management of chronic pain in primary care settings and the effectiveness of long-term opioid therapy remain controversial and largely understudied. However, one study to determine the efficacy of long-term opioid therapy for improving pain and function with minimal side effects or risk found that in "typical" chronic pain patients, psychological factors are significant and opioids appeared to do more harm than good. Long-term opioid therapy use was found to be appropriate for only a very small, carefully selected group of patients.

The American Pain Society and the American Academy of Pain Medicine commissioned a systematic review on opioid therapy and noted a similar finding: chronic opioid therapy can be an effective choice for *carefully selected and monitored* patients with chronic noncancer pain. However, the *Journal of Pain* reports in its "Opioid Treatment Guidelines," that "opioids are also associated with potentially serious harms, including opioid-related adverse effects and outcomes related to the abuse potential of opioids." The Guidelines recommend that patient selection and "risk stratification" include a comprehensive benefit-to-harm evaluation that weighs the potential positive effects of opioids on pain and function against potential risks, or the

likelihood for drug abuse, misuse, and addiction. In addition to determining the underlying biological source of pain, the risk stratification evaluation must also include a thorough assessment of psychosocial factors and family history.

As noted above, *pain results from a combination of biological, psychosocial, and social factors*, and often requires comprehensive approaches to prevention and management. Treatment options for pain include pharmacological and/or nonpharmacological modalities, and problems frequently arise when those managing patients' chronic pain opt for the former instead of or without the latter.

Treating Pain: The Biopsychosocial Model

Pain management methodologies among physicians and treatment specialists are shifting from a "biological model" of pain to one focused on the psychological and social aspects of chronic pain. Because pain often produces and is accompanied by psychological and cognitive effects such as anxiety, depression, and anger, according to the IOM's recent report, interdisciplinary, biopsychosocial modalities are the most promising for those with chronic pain. Nonpharmacological treatment options focusing on psychological aspects of pain include counseling, facilitation of self-care, cognitive-behavioral therapy, relaxation training, and psychotherapy for comorbid conditions.

The American Psychological Association (APA) is also advocating for integrated care in the treatment of pain, frequently referred to as a "mind-body" approach. As an example, the APA reported on psychologist Mark B. Weisberg's three-tiered intervention with pain patients:

- In the first tier, he teaches patients cognitive techniques to help prevent pain;
- then he focuses on specific stressors at work or home that exacerbate pain symptoms;
- and finally, for those with the most complex and chronic pain symptoms, he uses strategies such as hypnosis and focused psychotherapy to identify and attack emotions that may be setting off autonomic nervous system responses that aggravate physical symptoms.

Ultimately, it is important to remember that pain, including chronic pain, is a subjective experience, as each person perceives pain and its severity in a unique way. Understanding this, it is clear that indiscriminately prescribing opioids for individuals with chronic pain is not always an effective means for treatment, and in fact, studies have shown that opioid therapy may indeed be counterproductive, causing more harm than relief for certain patients. In short, the biopsychosocial (or integrated care) approach, which emphasizes the psychological and social aspects of pain, is integral to thorough chronic pain treatment.

How the Abuse of Prescription Drugs Manifests Itself in the Workplace

Opioid use has potentially devastating implications for chronic pain patients' functionality and return-to-work prospects. A 2009 study, published in *The Journal of Bone and Joint Surgery*, tracked patients who suffered a chronic, disabling occupational musculoskeletal disorder and were subsequently admitted into an interdisciplinary functional restoration program. Some participants reported opioid use at the time of admission and some reported no opioid use. The authors concluded,

"Chronic opioid use beginning after a work-related injury is a predictor of less successful outcomes for patients whose final treatment intervention is an interdisciplinary restoration program." Results indicated that a higher post-injury opioid dose was associated with a greater risk of program non-completion.

The authors also reported on socioeconomic outcomes, noting a relation between high opioid use and lower rates of return to work and work retention, as well as higher healthcare utilization. Furthermore, one year after the observed treatment, the group reporting the highest opioid use was 11.6 times as likely to be receiving Social Security Disability Income/Supplemental Security Income as compared with the group reporting no opioid use at the time of admission. A 2008 study on patients with chronic disabling occupational spinal disorders at the initiation of functional rehabilitation came to similar conclusions, i.e., prescription opioid dependence may be a risk factor for less successful long-term work and health outcomes.

Opioid use and abuse affects not only pain patients' functionality and motivation to return-to-work, but also has significant costs within the insurance and healthcare system, which ultimately increases costs for employers. According to a 2012 article in the *New York Times*, insurance payments (including workers' compensation) for major workplace accidents are being overtaken by the costs of routine workplace injuries that are treated with strong opioids. The article states that workplace insurers are now spending an estimated $1.4 billion annually for opioids, or narcotic painkillers, to which an individual can quickly become addicted, thus prolonging the time he or she takes to return to work. Generally, as indicated by the above-mentioned studies, when individuals are on opioids for long periods of time, they often do not return to work.

The article also states that while the cost of a typical workplace injury is approximately $13,000, that cost rises dramatically when painkillers are prescribed. Further, the strength of the prescribed painkiller is a factor:

- the average cost of a worker prescribed a short-acting drug like Percocet is $39,000, triple the cost of a typical workplace injury, and
- the cost of a stronger, longer-acting drug like OxyContin is tripled again to $117,000. The irony of the high cost for painkillers is that they became popular as insurers worked to cut back, or even phase out, physical (and mental) therapies as the usual treatment for non-major injuries. The result is higher costs in healthcare coverage for employers and employees.

Opioid use and abuse has many potentially disastrous implications for the workplace in the form of expenditures for health care, workplace injury, disability payments, productivity losses, and lost time. Thus, it is important for employers and human resources professionals to be familiar with the signs of and problems that arise from employee opioid abuse and addiction. The National Business Group on Health, in An Employer's Guide to Workplace Substance Abuse, references results from a survey of human resources professionals. According to the survey, the most significant problems companies experience due to employee substance abuse, including prescription drugs, are absenteeism, reduced productivity, lack of trustworthiness, negative impact on the company's external reputation, missed deadlines, increased healthcare costs, and unpredictable defensive interpersonal relations.

In addition to the extra monetary cost for employers, as well as health and safety

problems, it is seen in the human resources survey that the psychosocial issues that underlie and arise from opioid abuse, for example, can just as drastically affect work environments. Additionally, as mentioned above, workers who report opioid use after a workplace injury are less likely to succeed in their rehabilitation attempts. Opioid dependence can also engender injured worker helplessness, or the perceived loss of control in an injured worker and subsequent lack of motivation to return to work. These issues compound to create a significant and costly problem for employers and employees alike.

What Employers Can Do

The CDC stated in 2012: "Prescription drug abuse is the fastest-growing drug problem in the United States." In response, some states have legislated, or are considering legislation, to address the problem. Some ways employers are working with their legislators to support meaningful action on issues that impact the workplace include:

- The Internet System for Tracking Over-Prescribing (I-STOP) bill (New York)
- Setting up a state operated prescription monitoring database (New York)
- "Doctor shopping" for prescriptions recognized as a crime punishable by a year in jail (Alabama)
- Oversight powers on pain-management clinics (Indiana)
- Licensing of pain clinics (Kentucky)
- Setting dosage limits for doctors prescribing pain medications (Washington state)

Since many, if not most, abusers are employed, this kind of advocacy can return significant rewards for employers who urge the passage of such state laws.

For workplaces, safety programs that educate workers on the risks of prescription medication abuse and policies the company has developed to address the abuse of these drugs should be part of the organization's culture. SAMHSA provides programs specifically for employers in terms of prescription drug misuse, including its webinar on the prevention of prescription medication abuse in the workplace.

Alternate methods employers and their disability management programs could use as remedial approaches when substance abuse of opioids is identified include physical therapy, behavior modification, acupuncture, yoga, exercise, and/or weight loss. Dr. Caudill recommends life-style modifications, including mind-body techniques, increasing one's activity, developing and maintaining good nutrition, finding help for insomnia and sleep disorders, and reducing the use of alcohol.

These specific methods are aspects of the Employee Assistance Program (EAP) already operating in many companies. EAPs will serve an increasingly important role, especially when substance abuse seems to be associated with absenteeism, presenteeism, and other workplace dysfunctions. EAPs have been a substantial asset to employers and employees who struggle with both the occupational consequences of illicit and prescribed drug abuse and chemical dependency. When there is no EAP, the company may find specific resources readily available at contract events in the local community.

Articles Available from CEC Associates, Inc., on Pain and Disability

CEC Associates, Inc., has sought, over the years, to identify resources for employers on the issue of chronic pain. We recognize that pain has long been a primary concern for employers as they have tried to address issues of absenteeism and productivity. For more on pain in the workplace, see the following CEC articles:

- Pain as a Disability / Issues in Pain as a Disability
- A Pain in the Back / Back Problems: Specific Issues / "Well-Managed" Companies & Return-to-Work Programs (three parts)
- Strategies for the Use of IMEs: Assessing Pain in the IME
- Explaining Acquired Disability & The Workplace Approach to Managing It
- Workipedia - Chronic Pain
- Injured Worker Helplessness: Critical Relationships and Systems Level Approach for Intervention

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Drug Screening

With the high rate of opioid abuse, employers may find it necessary to verify and document the abuse by conducting credible drug screening before hire and/or at moderate intervals during employment. The prerequisite of the screening will be the qualifications of the screening agent, and the assurance that the findings will stand up

in litigation.

Generally, certified local agencies may be preferable for this sensitive activity. If there is no suitable local entity, one web-based company that does employment screening, including criminal background checks and drug screening, is Peopletrail.

Are You A Supervisor?

The issue of exactly who is a supervisor can be a critical issue in a lawsuit. When employers are involved with litigation involving the Fair Labor Standards Act (FLSA), it is important that the individual in the company involved with the issue know the definition of a supervisor as established by the U.S. Supreme Court in 2013.

According to the Court ruling, to be a "supervisor," the individual must meet a "four factors" test. He or she must:

- have the power to hire and fire employees;
- supervise and control employees' work schedules or conditions of employment;
- determine the rate and method of payment; and
- maintain employment records.

The Future of Domestic Partners Benefits

As most employers are likely aware, the Supreme Court ruled (in U.S. v. Windsor) that the Defense of Marriage Act (DOMA) would no longer be the law of the land. The question for employers now is what they need to know in respect to employee benefits.

The Society for Human Resources Management (SHRM) is a useful tool for employers and human resource professionals who want to know how the recent Court ruling affects their workplace. Visit SHRM's website for more on "The Future of Domestic Partners' Benefits."

FutureWork

The U.S. Department of Labor (DOL) has created a new website called "FutureWork." The site contains articles (with charts and statistics) in nine sections (e.g., Work and Family). The FutureWork program aims to address "Trends and Challenges for Work

in the 21st Century."

Some of the articles include:

- What the fastest-growing jobs require.
- Workers with disabilities are an underrated resource.
- How can workers balance their need for both life-long economic security and the resources and time to care for their families?
