

Joint Senate Task Force on Opioids, Addiction and Overdose Prevention  
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In 1804, Frederick Serturner experimented with opium and created something new—morphine—named after the Greek god of sleep and dreams, Morpheus. More than 200 years later, hundreds of thousands of New Yorkers fall asleep at night under the influence of an opioid. Every morning, a few of them don't wake up.

The United States comprises about 4% of the world's population but consumes about 80% of the world opioid supply. So why is it that when we travel abroad we're not shocked by the number of people we run into who are obviously wracked by pain? The answer is that opioids are not a good solution to chronic pain, in part because of what's known as "opioid-induced hyperalgesia", a paradoxical and tragic phenomenon in which opioids come to make people increasingly sensitive to pain. Two recent studies that focus on the effectiveness of non-opioid pain management highlight how far removed the overprescribing of opioids is from evidence-based practice. The studies, one involving acute pain, the other chronic pain, both found that combinations of acetaminophen and ibuprofen (Tylenol and Advil) were as effective as opioid-based interventions. And there are many other non-pharmacologic interventions for chronic pain whose effectiveness is evidence-based. So opioids are not a good answer to chronic pain, rather, they cause addiction and death. Routinely referring these patients for non-pharmacologic interventions is one of our recommendations.

So it's clear that a sea change must occur in the way that health care providers think about, treat and especially prescribe for pain. The task is really two-fold. First, what should be done for the thousands of New Yorkers who are addicted to opioids- how can we prevent as many of them as possible from adding to the opioid overdose statistics? Second: what can be done to prevent more people from finding themselves in the same situation- people who are showing up in medical offices now, looking for relief but putting themselves at risk for addiction?

Where do we go from here?

Towards answering these questions, last year the Division on Addictions of the New York State Psychological Association created a White Paper on the Opioid Crisis. It was distributed at the time to all members of the New York State Legislature and has been shared today with all of you. I trust that a careful review of the paper will demonstrate that there are already many programs, interventions and strategies available now that, wisely-deployed, would go a long way towards helping solve the Opioid Crisis. Among many other recommendations, we support providing evidence-based training about substance misuse and the risks of opioid-based pain medication for medical and mental health professionals, students and the general public. No patient with chronic pain goes to a medical office eager to become addicted to a potentially life-threatening medication. Only when the prescriber and the consumer both understand that the treatment for pain need not include the risks of addiction and death can an adequate response to this aspect of the opioid epidemic be said to be in place.

We support the strengthening of all programs that are designed to prevent new cases of opioid addiction and those that improve access to interventions that keep the already-opioid-dependent alive, such as methadone, buprenorphine, naloxone. clean needles, etc.

But we are never going to solve the opioid crisis until we recognize that addiction is a complex phenomenon that involves biological, social and psychological elements. And complex as addiction is on its own, it often co-occurs with other psychiatric disorders, such as depression and PTSD. So we can, and should, maintain our focus on improving prescribing practices, preventing

opioid diversion, using I-Stop, etc, but none of these address the root causes and issues that people with Opioid Use Disorders are confronted by. We can't simply enforce our way out of this epidemic, since pharmaceutical companies and prescribers do not control the supply of available opioids. With easy access to heroin, and the widespread presence of Fentanyl in the illegal drug supply, many people may simply turn to alternative opioids that it's now virtually impossible to use without being at risk for overdose death.

We are all now familiar with the term Medication Assisted Treatment, or MAT, often applied to buprenorphine and other addiction-specific medications. But I would ask: What is the Treatment that the Medication is supposedly Assisting? Often, there is none.

The psychological component in addiction is too often overlooked. Evidence for this lies in the frequency of relapse, even after withdrawal has been achieved and even when MAT is in place. There are frequently underlying psychological conditions that the individual is attempting to medicate with a substance; until that psychological condition is addressed, relapse is a risk. Although no single treatment intervention should be mandatory, effective evidence-based treatment should be offered, including counseling with licensed mental health providers who are substance use experts or licensed substance use disorder programs that include individual, group and family therapies, and include treatment for co-occurring disorders. These are treatments that operate from a person-centered, harm-reducing framework as opposed to treatments that merely operate at the level of the drug itself.

Why not require that health care providers provide referrals to substance use treatment for opioid overdose survivors and patients coming out of emergency department visits, rehabilitation and detoxification facilities? (That's one of our recommendations).

Why not ask prescribers who are checking I-Stop and are concerned about a possible addiction to make a referral to an appropriately trained clinician for an addiction risk assessment? The decision to prescribe or not prescribe is important, but why not take the opportunity to try to address the broader issues presented by a patient who won't get all of the help they need, whatever the prescriber ultimately decides.

We believe that a solution to the opioid epidemic is attainable. We look forward to working with our colleagues in government, healthcare, education, law enforcement and other arenas to create a comprehensive approach that reduces the frequency of opiate overdose and death in New York State and serves as a model that other states can benefit from.