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Barrier impacting the NP role in combating the opiate epidemic

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### Abstract

Serious opioid dependence and addiction has penetrated all geographical and socioeconomic levels of today's society. For decades, the opioid epidemic has been considered a grave public health problem for in United States. The crisis started with physicians recommending extra opioids, resulting to the drugs being proliferated among patients and children going through their parents' cabinets, the black market where patients are sold extra pills, and friends and family members getting opioids as gifts (Knudsena, Lofwallb, & Walshd, 2015). Drug overdose is actually a leading cause of injury death in America, and nurses are charged with the responsibility of getting involved and educating patients together with the public about the present opioid pandemic. Moreover, about 30 million Americans reside in counties where zero doctors and NPs have the necessary federal waiver to recommend buprenorphine.

Currently, about 20% of individuals take opioid painkillers for severe pain, one in every four misuse their recommendation, and about 10% become addicted (Knudsena, Lofwallb, & Walshd, 2015). Significant gaps in Medication-Assisted Treatment (MAT) have been identified compared to national need. Additionally, decentralized resources, transportation limitations, a lack of overall awareness of what MAT entails, and misinformation can keep individuals from seeking the necessary treatment (CSS, 2018). The American opioid pandemic has taken the lives of many individuals with all levels of education. As a matter of fact, individuals with lower educational levels experience restricted job chances and poor economic possibilities, thus leaving them prone to despair, drug addiction, and depression. Insufficient coverage from both public and private insurers is another challenge. Health insurers make families and patients go the extra mile to obtain coverage for the necessary outpatient and inpatient care for opioid addiction, with the inclusion of Medication-Assisted Treatment. Access to effective opioid addiction treatment is actually the

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missing piece in America's unstable battle against the opioid pandemic (CSS, 2018). The NPs and doctors who recommend America's medications are being equipped to be more judicious in their utilization of opioids to treat pain. Emerging NPs can also anticipate experiencing increased education with regards to secure prescribing practices. Resources on opioid-connected subjects have also been and will continue to be established as a type of constant education for practicing nurses.

### Barriers Impacting the NP Role in Combating the Opiate Epidemic

In the United States, the opioid epidemic is considered a serious public health problem, ensuing from amplified use of recommended and un-recommended opioid medications (Suzuki, Ellison & Renner, 2016). Drug overdose is actually a leading cause of injury death in America, and nurses are charged with the responsibility of getting involved and educating patients together with the public about the present opioid pandemic. In 2016, 1 out of every 3 American adults was given a recommendation for opioid painkillers such as hydrocodone, morphine, or oxycodone to control pain (Bartlett, Brown & Shattell, 2014). These medications are usually a significant element of care for those suffering from intense pain, but do not come without severe side-effects. According to Dempsey and Reilly (2016), Studies reveal that more than 2 million individuals tend to abuse their recommended pain relievers, and for the very first time, drug overdose fueled by the opioid epidemic is the leading cause of injury-associated death in America, compared to firearms and car accidents.

Presently, about 20% of individuals take opioid painkillers for severe pain, one in every four misuse their recommendation, and about 10% become addicted (Knudsen, Lofwall, & Walsh, 2015). The Comprehensive Addiction and Recovery Act (CARA) was signed into law in 2016 to address the increasing incidence of opioid abuse disorder, which affects an estimated 3 million Americans (CSS, 2018). Furthermore, this new law acknowledges the advantage of Nurse Practitioners (NPs) in combating the opioid crisis. NPs can seek a federal waiver which allows them to recommend anti-addiction drugs such as buprenorphine in order to prevent withdrawal symptoms (Flynn, 2017). NPs are also positioned as an important element in the battle to solve the opioid crisis. This paper will not only focus on the role of NP in combating the opiate crisis, but also look at some of the barriers to this particular effort.



## Discussion

Nurses are, on a daily basis, faced with the present issue of opioid use in the United States. The impact of this pandemic tends to affect all persons and families across the lifespan, whether due to the effects on the family unit, or direct drug use (Suzuki, Ellison & Renner, 2016). Patients suffering from substance abuse problems are present in every area of nursing practice, giving nurses the chance to establish rapport through the nurse-patient association and provide a secure platform for patients to reveal drug use. NPs are generally positioned to make huge impacts in reducing opioid overdose in specialty practices and basic care.

### ***Barriers impacting the NP role in combating the opiate epidemic***

Today, obsolete laws in some states tend to prevent NPs from wholly using their training and education to combat the opioid pandemic and address the significant access challenge experienced by patients (Bartlett, Brown & Shattell, 2014). It has already been established that eliminating legislative restrictions for NPs to provide independent care can greatly improve patient results, and where addiction is concerned, it means saving lives. NPs are available and ready to lead, but a number of barriers prevent them from practicing their role in combating this particular crisis. Some of these barriers include outdated stereotypes, racism, and ignorance, lack of access to Medication-Assisted Treatment, bureaucratic and regulatory hurdles, lack of education, and insufficient coverage from both public and private insurers, among others (Dempsey & Reilly, 2016). These are discussed in detail below.

### **Outdated Stereotypes, racism, and Ignorance**

Serious opioid dependence and addiction has penetrated all geographical and socioeconomic levels of today's society. However, for some particular reason, white Americans have been disproportionately impaired by the opioid pandemic, due to racism and stereotyping. The

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crisis started with physicians recommending extra opioids, resulting to the drugs being proliferated among patients and children going through their parents' cabinets, the black market where patients are sold extra pills, and friends and family members getting opioids as gifts (Knudsen, Lofwallb, & Walshd, 2015). Recent research also reveals that NPs and doctors are more hesitant to recommend painkillers to people of minority groups, because they mistakenly believe that minority patients are less susceptible to pain or are more likely to abuse and sell the drugs (CSS, 2018). In some ingenious way, this protected minority patients from the outbreak of opioid painkiller recommendations that eventually got Caucasian Americans addicted to these drugs, with the inclusion of heroin, leading to a wave of serious overdoses (Flynn, 2017).

There are those who believe that class also plays a role in opioid addiction and misuse. This pandemic has been linked to middle-class white Americans who have lately received an overwhelming quantity of media attention (Suzuki, Ellison & Renner, 2016). Keeping in mind that the media has an authoritative influence over the shaping of public attitude and public policy, it is important to evaluate ways in which it contributes to the discourse surrounding the opioid epidemic. While habitual intravenous drug use has been connected to the lifestyles of addicts, recreational drug use, on the other hand, has been represented as a main feature of young drug addicts (Bartlett, Brown & Shattell, 2014). Research on media coverage of opioid addiction, states that it is disproportionately aimed at certain stereotypes of drug users. Since the media largely shapes addicts as constant drug seekers who will not transform their degree of use, irrespective of possible outcomes, reactions targeting the addict typology generally fail to consider those who actually wish to transform their degree of drug use (Dempsey & Reilly, 2016). The stigma of seeking treatment of opioid addiction is embedded in many communities across the

globe. This societal factor tends to discourage individuals from seeking care, as they are afraid of being isolated or seen differently by their communities.

### **Lack of access to Medication-Assisted Treatment (MAT)**

This is a good illustration of a treatment alternative that has proven to be quite effective in assisting individuals recover from opioid use disorder. Unfortunately, most patients do not receive it. Medication-Assisted Treatment programs tend to focus on recommending the medications in safe doses, ideally together with educational, behavioral, and medical forms of treatment (Knudsen, Lofwall, & Walsh, 2015). Significant gaps in MAT capacity have been identified compared to national need. About 30 million Americans reside in counties where zero doctors and NPs have the necessary federal waiver to recommend buprenorphine. This is one of the most accessible MAT alternatives because it can be recommended and dispensed in doctors' offices, unlike methadone treatment which must be given in a superiorly structured clinic (Flynn, 2017). The lack of MAT availability makes it harder for one to start treatment and continue to finish the course of treatment without interruption.

Discovering and accessing the sparse MAT offerings are important challenges for individuals seeking care. Decentralized resources, transportation limitations, a lack of overall awareness of what MAT entails, and misinformation can keep individuals from seeking the necessary treatment (CSS, 2018). Different eligibility problems also limit access to MAT treatment options.

Some patients in some states like New York and California are required to provide evidence that they have made an effort to detox two or three times and later relapsed prior to the state paying for treatment with buprenorphine or methadone (Flynn, 2017).

### **Bureaucratic and Regulatory hurdles**

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Governmental and private information indicates that the number of recommendations for opioids has been declining since 2012 (Suzuki, Ellison & Renner, 2016). The CDC also produced a guideline four years later, recommending shorter durations for opioid prescriptions and the utilization of nondrug treatments for pain (Bartlett, Brown & Shattell, 2014). It was suggested that opioid doses should be kept lower than the average 90 milligrams of morphine. Unfortunately, the organization was silent on how to care for those already receiving doses that are superior to the recommended threshold. A majority of pharmacy plans are already implementing this approach (Dempsey & Reilly, 2016). However, they fail to consider the numerous patients suffering from severe pain who would lose access to the medications they are presently taking, all in the name of eliminating the death toll highly defined by non-recommended opioids such as fentanyl and heroin.

There have been no forthcoming clinical researches to indicate that discontinuing opioids for presently stable pain patients assists those patients or anyone else. Although this could greatly assist some patients, it will eventually destabilize others and most likely encourage the abuse of heroin or other drugs (Knudsen, Lofwall, & Walsh, 2015). Pain patients presently prescribed opioids for the long run are now involuntary participants in a test, where their lives are at stake. Overall, the drug distributors, manufacturers, chain drug stores, and wholesalers have a huge influence over Congress, to the extent that they can get the Congress to pass a bill safeguarding their interests in the height of an opioid crisis (Flynn, 2017).

The drug industry, for instance, spent an estimated \$102 million lobbying Congress on the bill and other laws between 2014 and 2016. The White House was unaware of the bill's import when the former US President, Barack Obama signed it into law (CSS, 2018). The DEA battled the bill for many years in the face of increased stress from major Congress members and in-

dustry lobbyists (Newton, 2018). Unfortunately, the agency lost the fight and was coerced into embracing a deal it did not want (Flynn, 2017). Notably, drug industry professionals and experts blame the origins of the opioid epidemic on the over-recommending of pain pills by physicians. Moreover, it also complained that the DEA communicated inadequately with organizations and was too penalizing when narcotics were sidetracked out of the official drug distribution channel (Suzuki, Ellison & Renner, 2016).

### **Lack of education**

The American opioid pandemic has taken the lives of many individuals with all levels of education. However, the death tolls have increasingly been more focused among those with lower levels of education, particularly the racial minority groups. Studies have revealed that more literate adults in America usually live longer than their less literate counterparts (Bartlett, Brown & Shattell, 2014). Furthermore, individuals with lower educational levels experience restricted job chances and poor economic possibilities, thus leaving them prone to despair, drug addiction, and depression. Illiterate individuals are more concentrated in rural regions where emergency medical response for overdose victims are more restricted (Dempsey & Reilly, 2016). They also tend to work in environments that are highly risky in terms of chronic health conditions, injuries, and disability, leading to a superior likelihood of being recommended opioid painkillers and eventually raising their risk of addiction (Knudsen, Lofwall, & Walsh, 2015).

Given that NPs practice in numerous executive, care-coordination, direct-care, and leadership roles, they are generally in a position to assist patients together with their families comprehend the advantages and risks of pain treatment alternatives. As teachers and patient supporters, NPs are in a special position to assist patients with non-opioid pain management with the inclusion of regional anesthetic interventions, surgery, physical/rehabilitative therapy, Complemen-

tary and Alternative Medicine (CAM), and mental therapies (CSS, 2018). Recently, there have been reports of NPs incorrectly prescribing opioids or overmedicating them to patients suffering from severe pain (Ostling et al., 2018). There have also been instances where the nurses hesitate or refuse to prescribe buprenorphine as they are uneducated on the right doses. Still, other NPs are somewhat stereotypical and biased when providing treatment to opioid addicts, for instance being discriminative towards racial minorities, and instead attending to white patients, or those who are wealthy (Flynn, 2017).

A genuine need to educate NPs on how to prescribe opioids safely and how to safeguard their patients together with their practices has so far been identified. Lack of use of opioid abuse tools, particularly in the rural regions has also been identified where NPs have no idea of how to go about their duties in providing adequate care for opioid addicts (Suzuki, Ellison & Renner, 2016). About one-third of American citizens blame doctors and NPs for the recommended painkiller abuse issue.

### **Insufficient coverage from both public and private insurers**

There is an obvious distinction between the number of individuals in need of addiction treatment in America, and those who actually receive it. In 2016, 21 million individuals above 12 years of age were in need of substance abuse treatment (Bartlett, Brown & Shattell, 2014). Unfortunately, only 18% of them were able to access the necessary treatment. Most individuals go untreated for various reasons, such as reluctance due to certain beliefs, or may not have insurance to cater to the expenses. A patient using opioids and suffering from depression was advised to receive intensive residential treatment at one of the local centers. However, the insurer insisted such treatment was not medically necessary, and the family could not cater to the program's high

expense on their own. Having no other alternatives, the patient had to refer to a less costly outpatient program that he had previously failed (Dempsey & Reilly, 2016).

The above is an illustration of the kind of fight with insurers that most patients and their physicians experience on a daily basis. Health insurers make families and patients go the extra mile to obtain coverage for the necessary outpatient and inpatient care for opioid addiction, with the inclusion of Medication-Assisted Treatment (Knudsen, Lofwall, & Walsh, 2015). Insurance helps in catering to the costs of substance abuse treatment, but most individuals remain uninsured due to losing Medicaid, transformation in family status, belief that they do not need insurance, and the loss of employment (Newton, 2018). It is unfortunate to learn that insurers require patients to be diagnosed as suicidal prior to paying for a stay at a detox center or residential rehabilitation center.

Opioid addict patients are forced to detox at home where there is a higher risk of relapse compared to how they would do in a facility (CSS, 2018). Additionally, those seeking addiction treatment are generally referred to an outpatient program having less oversight than a residential inpatient program. Though for some patients an outpatient program can be effective, others may require the structured care present in a residential facility (Ostling et al., 2018). Previous permission for MAT is considered another barrier resulting in insufficient insurance coverage. This approach usually mixes behavioral counseling with medication and is considered to be quite effective at minimizing the risks of relapse, thus improving chances of recovery (Flynn, 2017). Insurer's preceding permission policies require doctors and NPs to answer many questions regarding a patient's healing and prescription history before they receive consent to recommend MAT (Newton, 2018). This may take days or even months.



Although the Mental Health Parity together with the Addiction Equity Act (2008) bans insurers from applying cost-sharing and benefit restrictions on treatment for substance use disorders that are more limiting compared to those placed on other medical services, there is little enforcement of this law (Suzuki, Ellison & Renner, 2016). Furthermore, there are not enough NPs and doctors licensed and qualified to administer MAT, due to low payment rates and the numerous management hassles linked to providing this particular care (Ostling et al., 2018). Notably, insurance that covers MAT pays for only one of the three approved MAT medications, that is, naltrexone, methadone, or buprenorphine (Bartlett, Brown & Shattell, 2014). The naltrexone injection, for instance, works better than the pill form of the drug for patients having a difficult time staying sober. This injection requires a monthly shot while the pill must be taken daily. Insurers do not often pay for the injection (Dempsey & Reilly, 2016). They, together with other industry groups, have argued that the federal government should not coerce them into catering for specific treatments.

### **Overcoming the barriers impacting NP role in combating the opioid epidemic**

The discussion above has revealed that more than 1,000 individuals are sent to the emergency room for recommended opioid abuse (Knudsen, Lofwall, & Walsh, 2015). In most of these cases, opioids were used together with alcohol or medications meant to treat seizures or anxiety. When individuals combine such medications, they experience a greater risk of injury or even death as their breathing tends to slow down or come to a complete halt (Ostling et al., 2018). Effective treatments to this particular issue are present but remain inaccessible to most of those who need it (Newton, 2018). Access to effective opioid addiction treatment is actually the missing piece in America's unstable battle against the opioid pandemic (CSS, 2018). Triumphs in combating the opioid pandemic have been recorded on a number of instances. The NPs and



doctors who recommend America's medications are being equipped to be more judicious in their utilization of opioids to treat pain. They are also currently learning to consider non-opioid medications that do not come from pharmacies at all (Flynn, 2017).

As also indicated in the course of the discussion, Medication-Assisted Treatment has proved to be the most effective kind of treatment for opioid use disorders (Ostling et al., 2018).

Prescribers who have undertaken the process and education to get a DEA waiver to recommend MAT are restricted to doing so for only 100 patients (Suzuki, Ellison & Renner, 2016). They are required to apply for an increase in the patient restriction to 275, having met particular requirements (Newton, 2018). Law prior to Congress would also enduringly allow NPs and doctor assistants to treat patients with MAT medications such as buprenorphine (Bartlett, Brown & Shattell, 2014). It is, therefore, advised that such policy proposals be supported in order to effectively combat the opioid crisis (Newton, 2018). Together with MAT services, all NPs with their responsibilities as direct care givers, educators, patient supporters, and care coordinators play a significant duty in solving the opioid pandemic by assisting patients and their families comprehend the risks and gains of pain treatment alternatives.

Emerging NPs can anticipate experiencing increased education with regards to secure prescribing practices. Resources on opioid-connected subjects have also been and will continue to be established as a type of constant education for practicing nurses (Dempsey & Reilly, 2016). NPs should be able to evaluate patients carefully. This means that pain medications should correctly match the individual patient's needs (Ostling et al., 2018). In order to provide optimal patient care and safeguard themselves from legal action, NPs should practice evidence-based pain control (Knudsena, Lofwallb, & Walshd, 2015). They should also ensure that they finish regular

education courses in pain control and record they did so, providing proof of their know-how in the event of lawful action.

### **Conclusion**

With increased cases of opioid abuse in the United States, NPs play a crucial role in identifying those with opioid addiction and utilizing an empathetic, nonjudgmental, and caring approach. It is important for the nurses to be well educated and equipped to notice patients trapped in the thick of opioid abuse, evaluating each patient's individual circumstance with the aim of getting them the assistance they need. They have a chance to educate patients on the function of pain prescription in their care, incorporating pain prescription alternatives and reasons why non-opioids are a better option. Patient utilization of managed drugs should be closely monitored by the NPs and doctors so as to avoid overreliance or possible addiction, referring severe pain patients to a pain control expert or center.

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