

ACHA Guidelines

Opioid Prescribing in College Health

The United States is facing a prescription opioid epidemic. The U.S. Centers for Disease Control and Prevention (CDC) has reported prescription and sales of opioid medication has quadrupled since 1999. Between the years of 1999 and 2014, 165,000 people have died from an overdose of opioid pain medication in the United States.¹

A majority of pain medication prescriptions written in the college health setting are for acute pain, though some students need pain management for more chronic issues. College health providers may not feel comfortable prescribing long term pain management, but smaller or more rural campuses may not have access to qualified pain management specialists; providers thus may feel both obligated and unprepared to prescribe.

The ACHA Task Force for Opioid Prescribing in College Health has created these guidelines to further an understanding of the issues surrounding opioid prescribing; review major concepts designed to maximize safety and reduce potential for abuse; and identify possible avenues to assist addicted students with rehabilitation, recovery, and return to the college environment. These guidelines are not intended to be comprehensive, and national issues and recommendations may change over time. Therefore, college health professionals are encouraged to seek additional resources and specific clinical advice as indicated.

Acute Prescriptions

There is little evidence that opioid prescription pain medication is useful outside the treatment of cancer-related pain.² In addition, studies have shown that a prescribed opioid prior to high school graduation increases the risk of future misuse by 33%.³ As a result, the prescriber should be very judicious in the use of narcotics for acute injuries.

Basic concepts include:

- Avoid opioids when possible. NSAIDs and acetaminophen are quite effective for most pain, particularly when associated with inflammation.
- Prescribe opioids for time-limited use only. Keep in mind that 48 to 72 hours of opioid medication is generally sufficient in the acute setting. The provider should discuss with the patient how to switch to NSAIDs or acetaminophen after that time period.
- Discuss the risks and dangers of these opioid medications in detail with the patient, including the risk of addiction and overdose.
- Prescribe opioids in low doses and small quantities. There is no evidence that the extended release formulations are safer or more effective than shorter acting medication.²
- Consider close follow-up for confirmed discontinuation.
- Screen for substance abuse, poorly-controlled depression, family history of substance abuse, concomitant use of benzodiazepines, and other major psychiatric disorders. These conditions increase the likelihood of abuse and should be considered relative contraindications.

Chronic Pain

Chronic pain management is defined as the prescription of opioids for management of pain for more than three months. Evidence is insufficient to determine long term benefits of opioid therapy versus other approaches chronic pain management and suggests that harm may appear to be dose dependent.⁴ CDC recently released 12 recommendations focused on consideration of alternative options, prescribing the lowest possible dose, and when to taper and discontinue treatment.

¹Substance Abuse and Mental Health Services Administration “The DAWN report: highlights of the 2011 Drug Abuse Warning Network (DAWN) findings on drug-related emergency department visits.” Rockville, MD: US Dept of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality; 2013

²DuBosar, R. Prescribe opioids, but with caution, ACP Internist, July/Aug 2015. 35:7.

³Miech R et al. Prescription opioids in adolescence and future opioid misuse. Pediatrics/peds.2015-1364.

⁴CDC Guidelines for Prescribing Opioids for Chronic Pain, 2015. Available at <http://www.cdc.gov/drugoverdose/prescribing/guideline.html>.

The CDC recommendations outline the following considerations when prescribing opioids for chronic pain:

- Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for treatment of chronic pain. Prescribers should consider opioid therapy only if expected benefits for both pain and function outweigh the risks. If used, concomitant therapy should also be employed.
- Before beginning therapy, establish treatment goals and how and when medication will be discontinued. Medication should be continued only when there is meaningful improvement in pain and function.
- Many experts recommend a written contract with the patient outlining treatment expectations prior to beginning therapy.
- Prescribers should educate patients on risks and realistic benefits of opioid therapy.
- Untreated substance use disorders, poorly controlled psychiatric disease, and erratic treatment adherence should be considered as contraindications for opioid prescriptions.
- When starting therapy, prescribe the lowest effective dose. Caution should be taken if dosage begins to exceed 50 morphine milligram equivalents per day.
- Patients should be evaluated every three months, at a minimum, for benefits and harms.
- Frequent checks of state prescription drug monitoring programs can assist prescribers in determining if patients are receiving dosages or dangerous combinations that put them at risk for overdose.
- Urine drug testing for prescribed medication as well as other controlled or illicit drugs should be considered.

The American Academy of Neurology has stated that opioids should rarely be used to treat low back pain, headaches, or fibromyalgia, as the risks are almost always greater than the potential benefit.⁵

Overdose

Individuals who have recently stopped using opioids and then return to use have the highest risk of overdose. Individuals who mix substances, especially benzodiazepines, with opioids are also at an increased risk.⁶

Opioid overdose can be reversed with the opioid antidote naloxone and basic life support. Previously available only in medical settings, naloxone use has become more prevalent as awareness of opioid overdose has grown. Some college campuses have recently chosen to provide campus police and first responders with access to naloxone, and federal funding is available to allow states to purchase and distribute naloxone and to train first responders and others on its use. It can also be considered reasonable to prescribe naloxone along with prescription opioids, especially in chronic use patients. It should be noted that naloxone's half-life is shorter than immediate release narcotic pain relievers so it is important to transfer an overdose victim to a medical facility for extended monitoring following initial resuscitation.

A prepared college health center should consider the following:

- Adding naloxone to the emergency box or cart
- Ensuring that health center staff has adequate expertise and equipment to manage the airway of an unconscious patient
- Ensuring the health center has adequate expertise and equipment to provide intravenous fluid support
- Ensuring that emergency response, including EMS system activation, has been planned and appropriately drilled

Recovery from Addiction

The prevalence of non-medical opioid use in the college age population is 7-12%, and conversion from prescription opioid use disorder to heroin use is 2-3% per year.⁷ College health professionals should stay alert for signs of addiction and have in place a plan for intervention and treatment referral. Options for treatment

⁵ Franklin GM. Opioids for chronic noncancer pain: a position paper of the American Academy of Neurology. *Neurology*. 2014;83(14):1277-1284. doi:10.1212/WNL.0000000000000839.

⁶ Tobin, D et al. Prescribing opioids in primary care: Safely starting, monitoring, and stopping. *Cleveland Clinic Journal of Medicine*, 2016 Mar;83(3):2017-215

⁷ Johnston, L. D., O'Malley, P. M., Bachman, J. G., Schulenberg, J. E. & Miech, R. A. (2016). Monitoring the Future national survey results on drug use, 1975–2015: Volume 2, college students and adults ages 19–55. Ann Arbor: Institute for Social Research, The University of Michigan. Available at <http://monitoringthefuture.org/pubs.html#monographs>

include inpatient detoxification with abstinence, naloxone depot injections, daily methadone dosage, or office-based buprenorphine/naloxone sublingual preparation. Buprenorphine, an opioid medication used to treat opioid addiction, can be prescribed by a physician who has completed a course on addiction treatment and applied to the DEA for a waiver. Its use should be combined with counseling and/or recovery groups. Buprenorphine should be considered for treatment if the patient meets the following criteria:

- Opioid use disorder
- Interested in treatment and ready to comply with protocols and safety procedures
- Any co-occurring psychiatric conditions are stable
- No concurrent alcohol dependence
- Benzodiazepines are not used or doses are lowered
- Cautioned of interactions with HIV and seizure medication

Campus physicians should consider becoming certified to prescribe buprenorphine to be able to provide this life-saving treatment at their institutions.

Students entering or returning to campus from residential recovery or other treatment options may need additional support to navigate campus resources and maintain their recovery in the face of misperceived campus norms. Collegiate recovery communities can be vital to the success and retention of these students. Campuses will vary in the resources at their disposal, but if there are not collegiate recovery communities or recovery professionals on campus, information on community service providers should be available whenever possible. Further information about buprenorphine/naloxone treatment can be found in the *Journal of American College Health* article “The Implementation of Buprenorphine/naloxone in College Health Practice” by Peter DeMaria, MD, and Ashwin Patka, MD.

Engaging Campus Partners and Communities

Prescribing guidelines are just part of a comprehensive approach to this issue. Opportunities are available to engage campus and community partners to strengthen awareness; provide prevention, education and training; and develop environmental management strategies in addition to the processes described above.

Potential campus partners in these collaborative efforts include but are not limited to athletic and recreation

departments; emergency medical services; pharmacists, dentists, and orthodontists; facilities staff, housing and residence life; health promotion; collegiate recovery communities; religious organizations; counselors and advisers; and parents.

Efforts should be made to alert the campus community to the risks of opioid abuse. Faculty, staff, and students should be aware that those unable to afford prescription pain medication may switch to heroin for a lower-cost alternative. Training for all members of the community in overdose prevention and response would be ideal, similar to how communities are prepared to use fire extinguishers, fire alarms, and automated external defibrillators. Campuses may consider implementing a drug return program, through which students can bring medication they are no longer using to be properly disposed of. Campus thought leaders need to be mindful that some members of our campus communities may be the grieving parents, siblings, children, and friends of overdose victims or concerned loved ones of people living with addiction. Finally, multi-level prevention, intervention, and treatment strategies must respect the needs of our diverse populations and campuses should seek broad input when developing such strategies.



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