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

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 been 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 6gn492 0

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