# Pain, Opioids and Addiction

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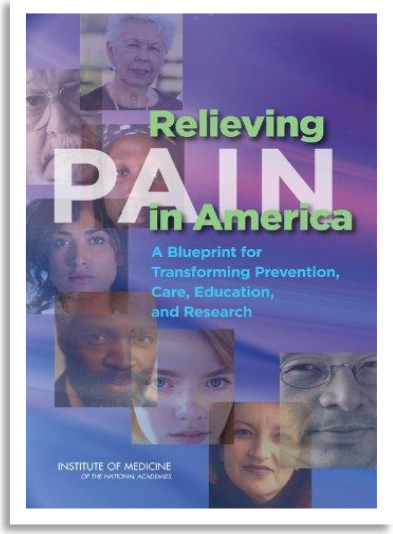
# Chronic Pain in Perspective




- 100 Million* in U.S. with chronic pain
- Chronic pain can be a disease in itself

**Significant barriers to adequate pain care include:**

- Negative attitudes and disparities in pain care
- Lack of decision support for chronic pain management
- Financial misalignment favoring use of medications
- Poor support for team-based care and specialty clinics
- Over-burdened primary care providers
- Regulatory, legal, educational and cultural barriers inhibiting the medically appropriate use of opioid analgesics

Institute of Medicine. 2011 Relieving Pain in America. Washington DC
*Dzau VJ, Pizzo PA. *JAMA* 2014
Reuben DB et al. *Ann Intern Med*. 2015

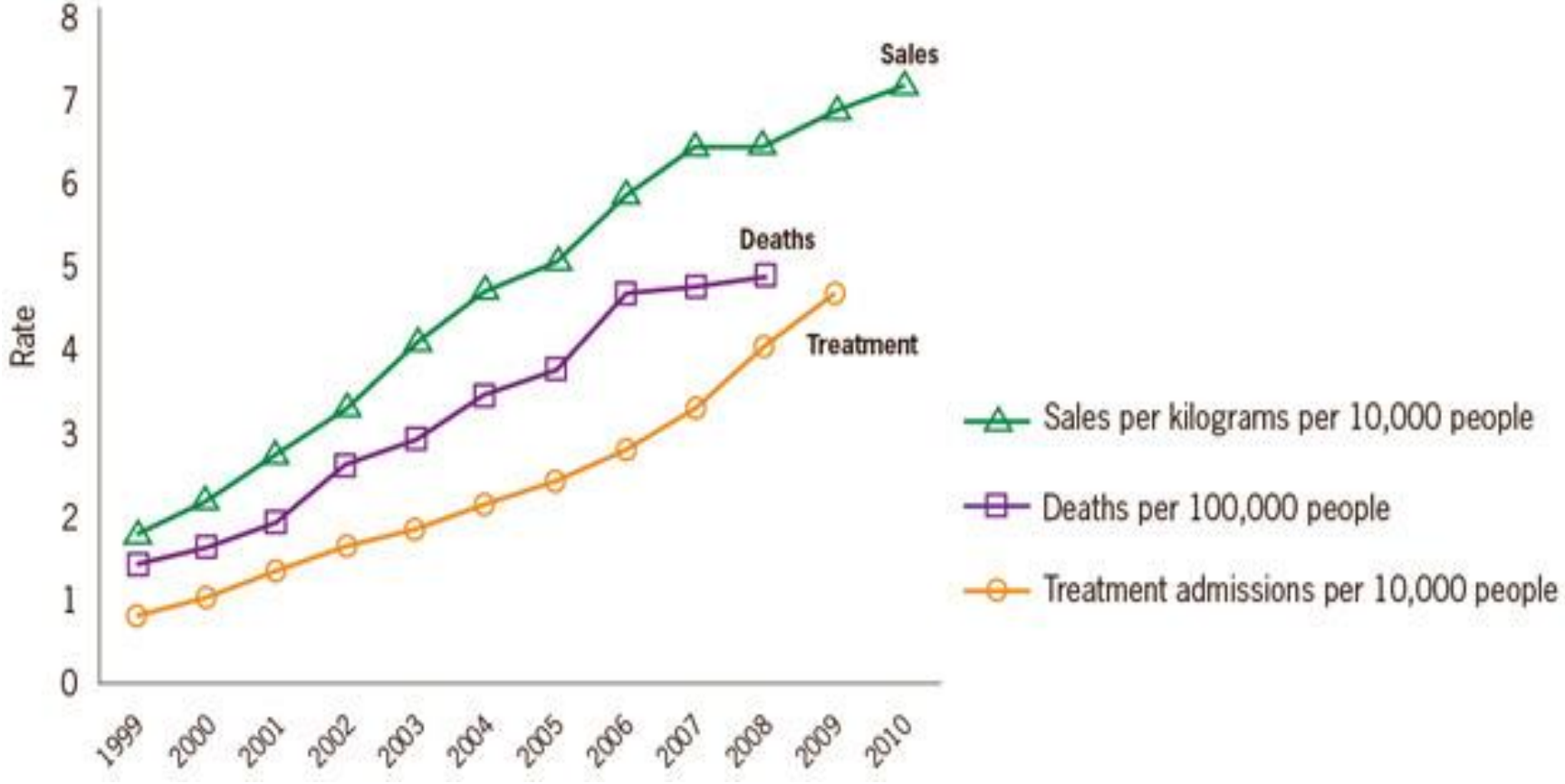
# “My chronic pain isn’t a crime”

Opinion The Boston Globe

- I will be in chronic pain until I die…I accept it.
- Pain medication is inadequate. But with it I am more consistently functional (homeowner, spouse, parent, teacher, writer, editor).
- Abuse of prescription pain medications is a serious problem; people are dying.
- Ever-tighter regulations…are of dubious value in reducing [abuse] – while causing grave harm to those of us in chronic pain, to the overwhelming majority who take medications for appropriate reasons.
- Increasingly I am a suspect, treated less as a patient and more as a criminal.

Donald N.S. Unger, MFA, PhD, English Department, College of the Holy Cross *Feb 03, 2015*

# Troubling Associations




National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the DEA, 1999-2010; Treatment Episode Data Set, 1999-2009

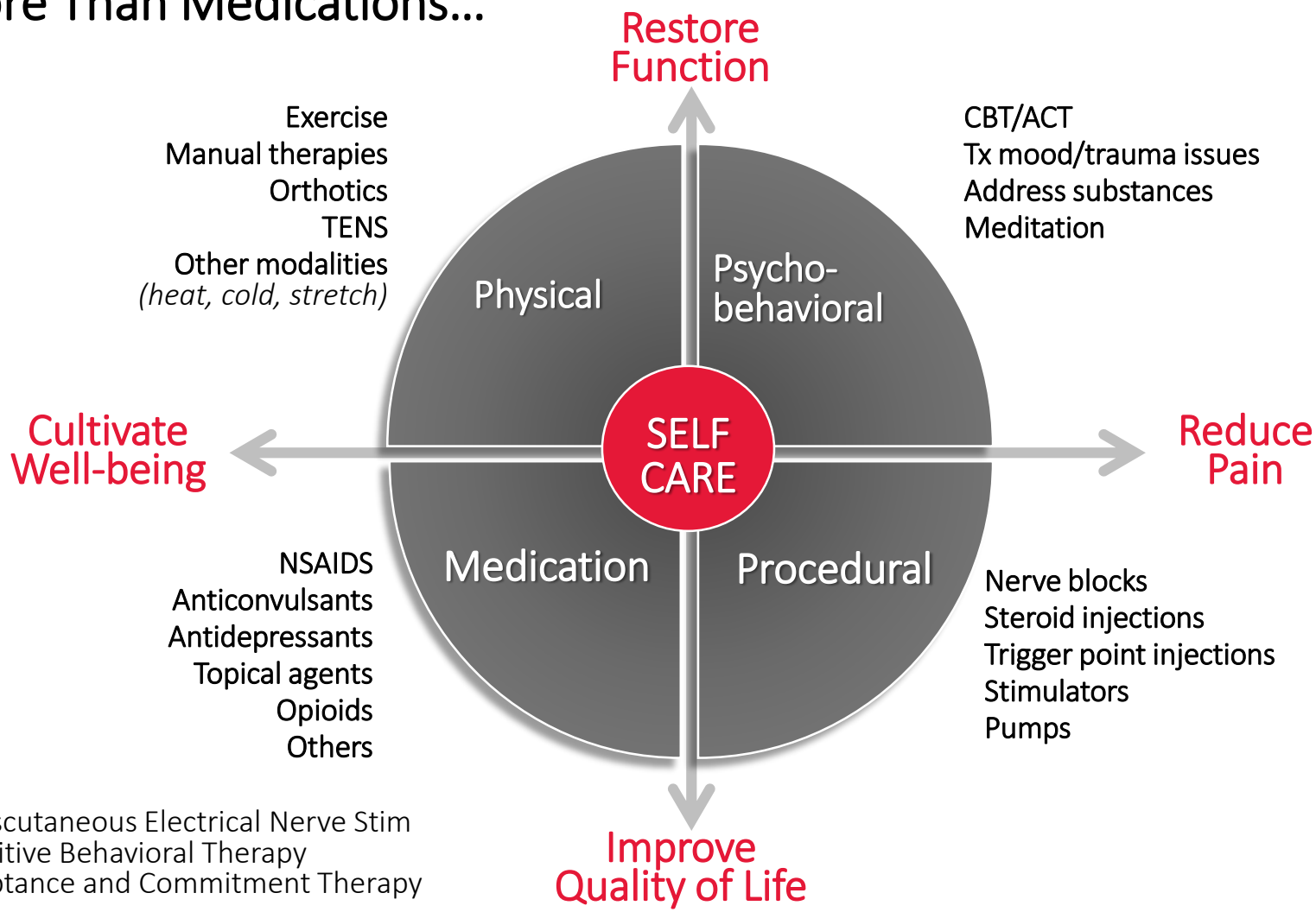
# Opioids in Perspective

- The efficacy and safety of chronic opioid therapy for chronic pain has been **inadequately studied**

- Opioids for chronic pain…
  - help ***some*** patients
  - harm ***some*** patients
  - are only one tool for managing severe chronic pain
  - are indicated when alternative safer treatment options are inadequate

# Multidimensional Care Needed

## It's More Than Medications…




TENS Transcutaneous Electrical Nerve Stim
CBT Cognitive Behavioral Therapy
ACT Acceptance and Commitment Therapy

# Chronic Pain is Complicated

- There are no “pain meters”
  - Pain is subjective to both the patient and the provider
- Pain can’t always be visualized even by our most sophisticated diagnostic imaging tests
- Pain is influenced by psychiatric co-morbidities and environmental stressors
- It is difficult to distinguish…
  - **inappropriate** drug-seeking (addiction) from…
  - **appropriate** pain relief-seeking

# Safe Opioid Prescribing

# Over-Prescribing Opioids

- Lack of training in pain and addiction at all levels of health professional education
- Societal medication mania
- Patients (families) overly focused on opioids
- Providers' confrontation phobia
- Providers' hypertrophied enabling

Mezei L et al. J Pain 2011
Watt-Watson J et al. Pain Res Manag 2009
Morely-Forster PK et al. J Pain Res 2013

# Over-Prescribing Opioids

- Lack of specialists for consultations
  - Lack of pain specialists and pain management programs
  - Lack of addiction specialists
  - Lack of combination pain and addiction management programs
- Lack of options other than medications
  - Lack of multimodal, multidisciplinary pain programs

Breuer B et al. J Pain 2007
Institute of Medicine. 2011 Relieving Pain in America. Washington DC

# Opioid Efficacy for Chronic Pain
## Inadequately Studied

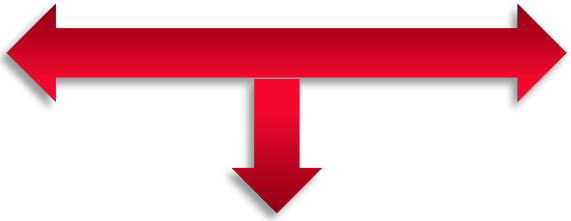
- Most literature: surveys and uncontrolled case series
- RCTs are short duration (<8 months) with small samples (<300 patients)
- Mostly pharmaceutical company sponsored
- Outcomes
  - Better analgesia with opioids vs. placebo
  - Pain relief modest
  - Mixed reports on function
  - Addiction not assessed


Ballantyne JC, Mao J. *N Engl J Med*. 2003
Chou R et al. *Ann Intern Med*. 2015
Eisenberg E, McNicol ED, Carr DB. *JAMA*. 2005
Furlan AD, et al. *CMAJ*. 2006
Kelso E, et al. *Pain*. 2004
Noble M, et al. *Cochrane Systematic Reviews*. 2010

# Benefit is Difficult to Measure

- How does one measure pain, function, and quality of life in primary care?
- How much improvement in pain, function and quality of life is enough?
  - Is a decrease in pain from an 9-7 on a 10 point scale enough?
  - Is walking 2 blocks to the store once per week enough?

# Harm is Difficult to Measure



## Pain Relief Seeking

- Disease progression
- Poorly opioid responsive pain
- Withdrawal mediated pain
- Opioid analgesic tolerance
- Opioid-induced hyperalgesia

## Pain Relief and Drug Seeking

- e.g., pain with co-morbid addiction, patient taking some for pain and diverting some for income

## Drug Seeking

- Addiction
- Other psychiatric diagnosis
- Criminal intent (diversion)

Alford DP. JAMA. 2013

# "Universal Precautions"

- Patient Provider Agreements
  - Informed consent
  - Plan of care
- Assess for opioid misuse risk
- Monitor benefit and harm w/ face-to-face visits
- Monitor for adherence, misuse (e.g., addiction, diversion)
  - Urine drug testing
  - Pill counts
  - Prescription Drug Monitoring Program (PDMP) data

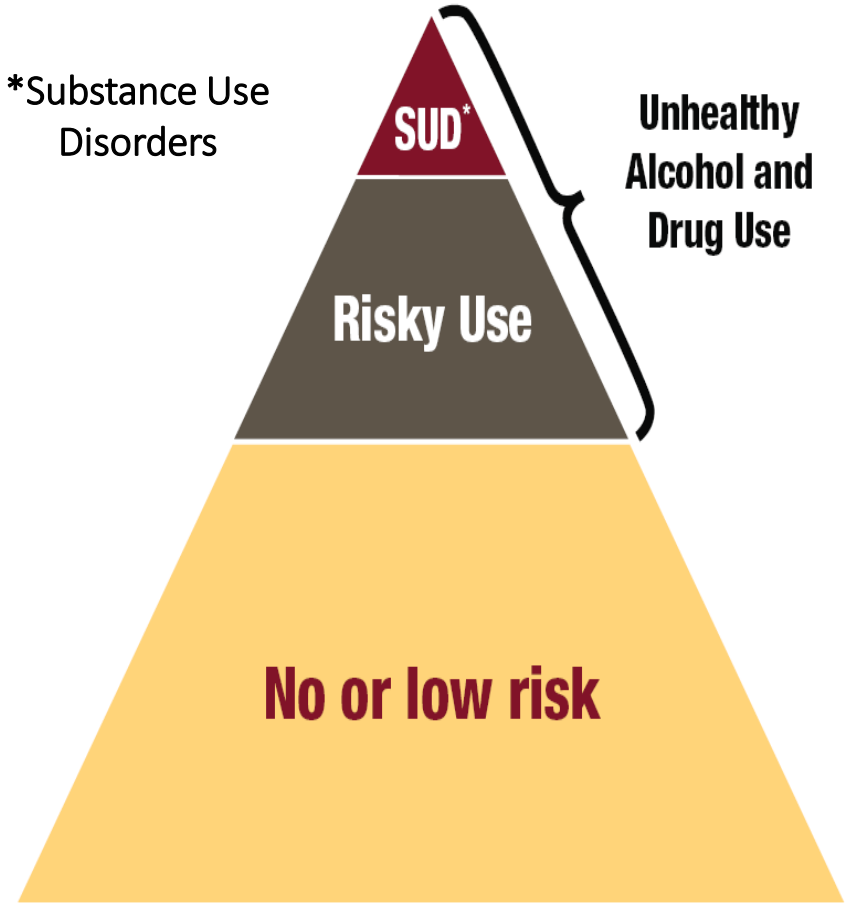
FSMB Guidelines 2013 www.fsmb.org
Gourlay DL, Heit HA. Pain Medicine 2005
Chou R et al. J Pain 2009

# Opioid Misuse/Addiction Risk

- Published rates of abuse and/or addiction in chronic pain populations are 3-24%
- Known risk factors for addiction to any substance are good predictors for problematic prescription opioid use
  - Young age <45 yrs
  - Personal history of substance abuse
    - Illicit, prescription, alcohol, nicotine
  - Family history of substance abuse
  - Legal history (DUI, incarceration)
  - Mental health problems

Akbik H et al. JPSM 2006
Ives T et al. BMC Health Services Research 2006
Liebschutz JM et al. J of Pain 2010
Michna E el al. JPSM 2004
Reid MC et al JGIM 2002

# Screening for Substance Use




## Alcohol

"Do you sometimes drink beer, wine or other alcoholic beverages?"

"**How many times** in the past year have you had 5 (4 for women) or more drinks in a day?"

(positive: > never)

## Drugs

"**How many times** in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?"

(positive: > never)

Smith PC, et al. *J Gen Intern Med*. 2009
Smith PC, et al. *Arch Intern Med*. 2010
*Image*: SBIRT Clinician's Toolkit www.MASBIRT.org

# Monitoring is a lot of work…engage staff

- Educate all staff on protocols and policies
  - How and when prescriptions will be dispensed
  - Appointments, program expectations
  - Pain management and addiction
- Be consistent: send the same message
- Engage the entire team to...
  - help educate and monitor patients
  - remind patients of policy and treatment agreement
  - manage refills
  - monitor for adherence

# Diagnosing Addiction

# Does my patient have an OUD?

- ✓ *Tolerance
- ✓ *Withdrawal
- ✓ Use in larger amounts or duration than intended
- ✓ Persistent desire to cut down
- ✓ Giving up interests to use opioids
- ✓ Great deal of time spent obtaining, using, or recovering from opioids
- ✓ Craving or strong desire to use opioids
- ✓ Recurrent use resulting in failure to fulfill major role obligations
- ✓ Recurrent use in hazardous situations
- ✓ Continued use despite social or interpersonal problems caused or exacerbated by opioids
- ✓ Continued use despite physical or psychological problems

*This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision

| | |
|---|---|
| **Mild** OUD: | 2-3 Criteria |
| **Moderate** OUD: | 4-5 Criteria |
| **Severe** OUD: | ≥6 Criteria |

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.)

# Is My Patient Addicted?

## Addiction (4 C's)

*Behavioral mal-adaptation*

- Loss of Control
- Compulsive use
- Continued use despite harm
- Craving

} Aberrant Medication Taking Behaviors *(Pattern & Severity)*

Savage SR et al. J Pain Symptom Manage. 2003

# Discontinuing Opioids

- Do not have to prove addiction or diversion - only assess and reassess the risk-benefit ratio
- If patient is unable to take opioids safely or is nonadherent with monitoring then discontinuing opioids is appropriate even in setting of benefits
- Need to determine how urgent the discontinuation should be based on the severity of the risks and harms
- Determine if the opioid needs to be tapered due to physical dependence

**You are abandoning the opioid therapy NOT the patient**

# Pain and Addiction

# Altered Pain Experience

- Patients with active opioid dependence have less pain tolerance than peers in remission or matched controls.
- Patients with a history of opioid dependence have less pain tolerance than siblings without an addiction history.
- Patients on opioid maintenance treatment (i.e., methadone and buprenorphine) have less pain tolerance then matched controls.

Martin J (1965), Ho and Dole V (1979), Compton P (1994, 2001)

# Potential Risks of Prescribing

- Prescribed opioid analgesic may serve as a trigger for relapse - “cross-addiction”
- Difficulty controlling use
- Patient may be pressured to supply opioids to addicted friends
- Patient may be tempted to sell opioids to supplement personal (disability) income

# Potential Risks of Not Prescribing

- Continued addiction-self medicating pain with alcohol and/or illicit drugs
- Unsuccessful detoxification because untreated pain worsens during withdrawal
- Increased distress and anxiety may trigger relapse to active alcohol or drug use

# Pain, Opioid Addiction, and Medication-Assisted Treatment

# Opioid Maintenance Treatment
# Acute Pain Management

- Patients who are physically dependent on opioids (i.e., methadone or buprenorphine) must be maintained on daily equivalence before ANY analgesic effect is realized with opioids used for acute pain management
- Opioid analgesic requirements are often higher due to increased pain sensitivity and opioid cross tolerance

Alford DP, Compton P, Samet JH. Ann Intern Med 2006

# www.scopeofpain.com

**SCOPE of Pain**
**Safe and Competent** Opioid Prescribing Education

BOSTON UNIVERSITY

About SCOPE | Resources | Trainer's Toolkit | Contact us | Ask the expert

## What is the SCOPE of Pain?

SCOPE of Pain is a series of continuing medical education/continuing nursing education activities designed to help you safely and effectively manage patients with chronic pain, when appropriate, with opioid analgesics. Our program consists of:

- A 3-module cased-based online activity; and
- Live conferences held around the US

**Live conferences** **Online training**

## Trainer's Toolkit

A resource to facilitate safe opioid prescribing training of physicians, NPs, PAs, nurses and other clinicians in your institution or practice.

**Access the toolkit**

## Additional Opioid Prescribing Education

After you have attended one of the SCOPE of Pain live meetings or completed the SCOPE of Pain online program, we suggest that you visit OpioidPrescribing.com. This online program provides in-depth training that focuses on effective communication skills as well as the potential risks and benefits of opioids and when and how to initiate, maintain, modify, continue or discontinue opioid therapy.

**Visit OpioidPrescribing.com**

# Pain Management and Opioid Addiction- Strategies to Ensure Safe Prescribing and Collaborative Care

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Sherry Nykiel, MD
Medical Director, Outpatient Services
Department of Psychiatry, Boston Medical Center
Instructor in Psychiatry
Boston University School of Medicine

# Overview

- Role for psychiatry and mental health in treatment of chronic pain?

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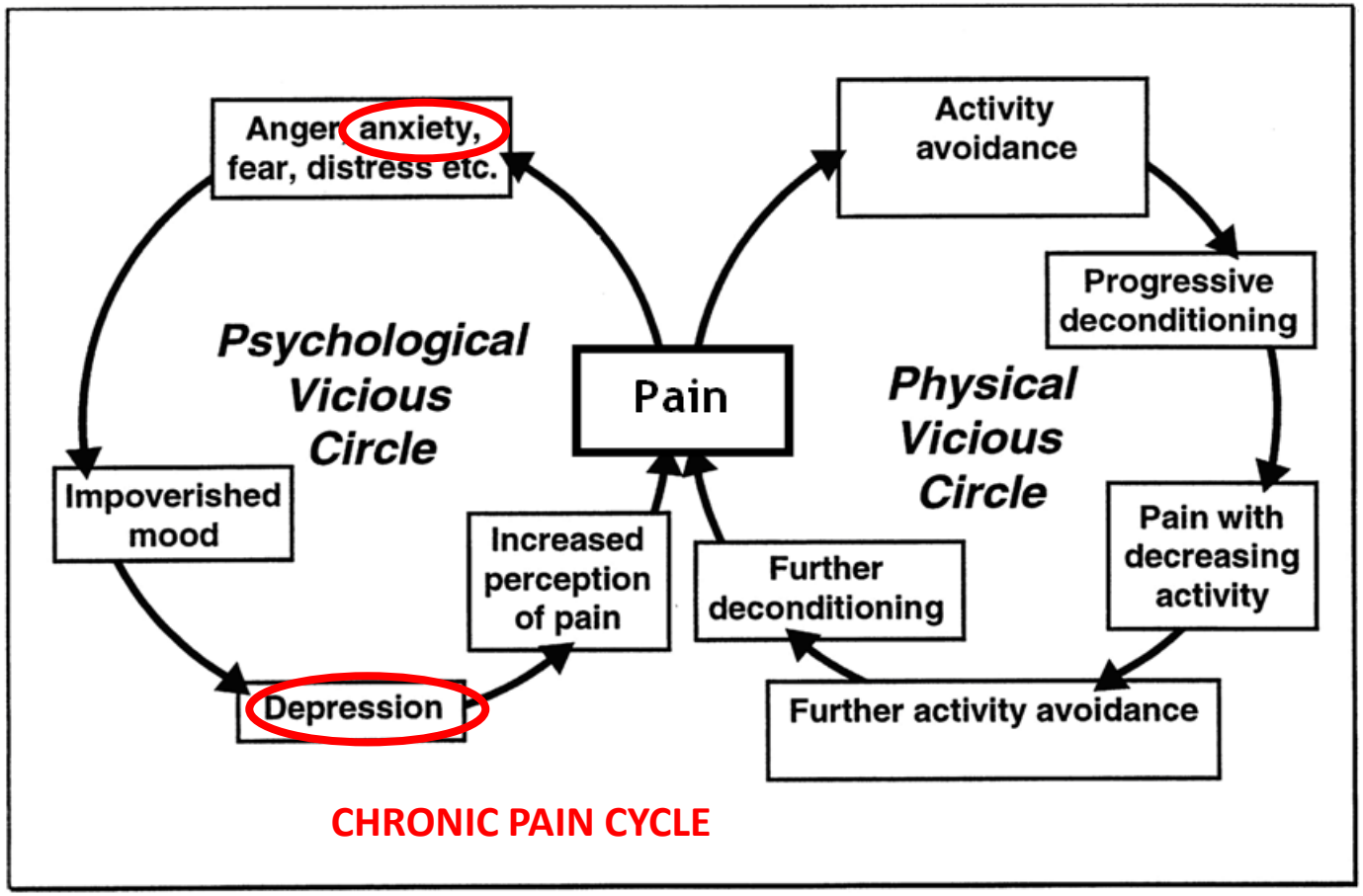
- Role for psychiatry and mental health in treatment of chronic pain?
  - Co-occurring psychiatric disorders and chronic pain
  - Co-occurring substance use disorders and chronic pain
  - Suicide and chronic pain
  - Non-pharmacological treatments for pain
    - Biopsychosocial treatment
    - “Pain School”

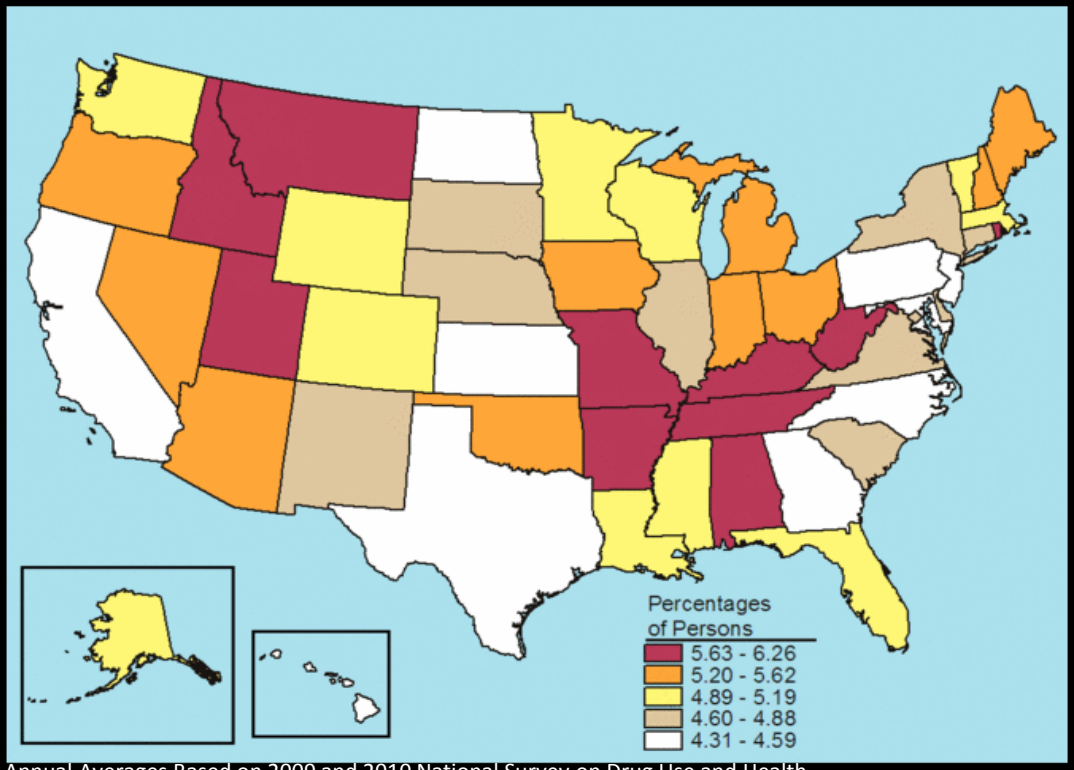
# Psychiatric Illness and Pain




http://osteonecrosis.me/tag/pain-management/

# Psychiatric Illness and Pain

*Serious Mental Illness in Past Year among Persons Aged 18 or Older by State*

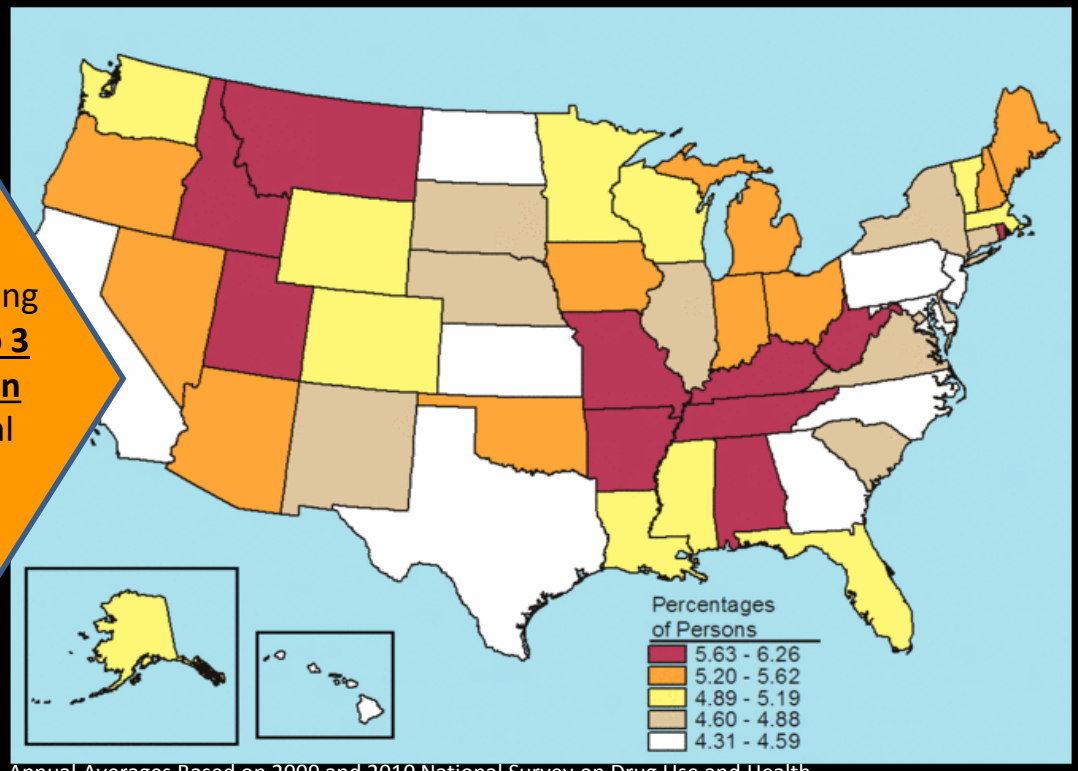



Percentages, Annual Averages Based on 2009 and 2010 National Survey on Drug Use and Health

# Psychiatric Illness and Pain

The incidence of co-occurring psychiatric disorders is **2 to 3 times higher in chronic pain patients** than in the general population

*Serious Mental Illness in Past Year among Persons Aged 18 or Older by State*




Percentages, Annual Averages Based on 2009 and 2010 National Survey on Drug Use and Health

# Psychiatric Illness and Pain

| Condition | Incidence in Chronic Pain Patients |
|---|---|
| Depression | 33-54% |
| Anxiety Disorders | 16.5-50% |
| PTSD | 2% |
| Substance Use Disorders | 15-28% |
| Borderline Personality Disorder | 58% |
| All Personality Disorders | 31-81% |

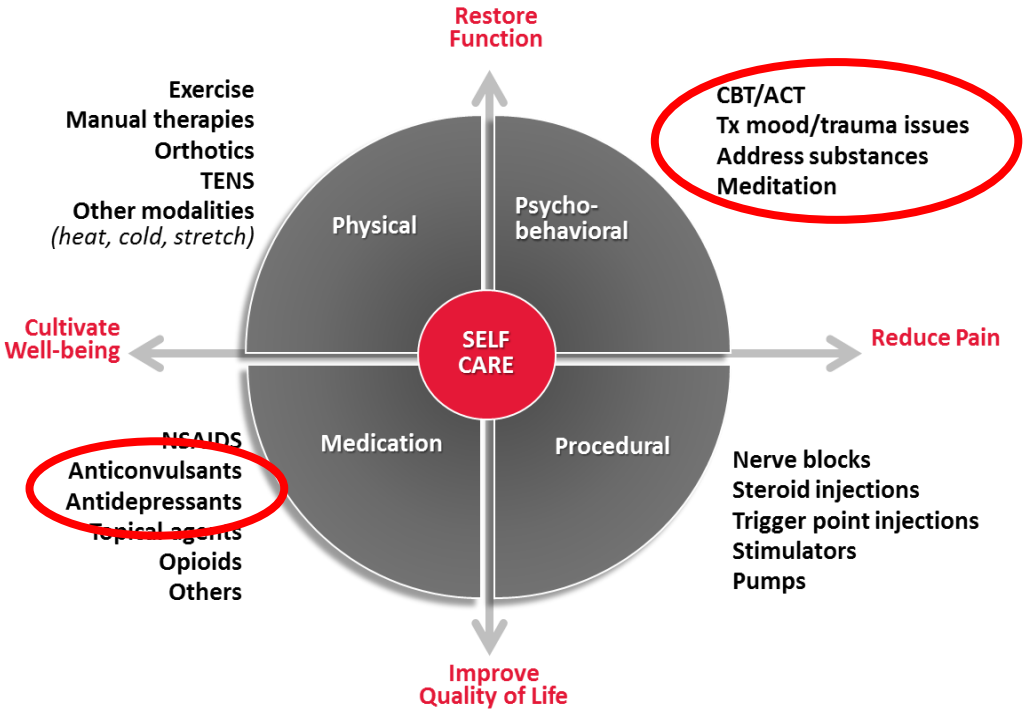
Cheatle M, Gallagher R, 2006
Dersh J, et al., 2002
Knaster P, et al., 2012
Otis, J, et al., 2010
Fischer-Kern M, et al., 2011

# Psychiatric Illness and Pain

- Most anxiety disorders occur before onset of pain
- Most depressive disorders appear after onset of pain

# Psychiatric Illness and Pain

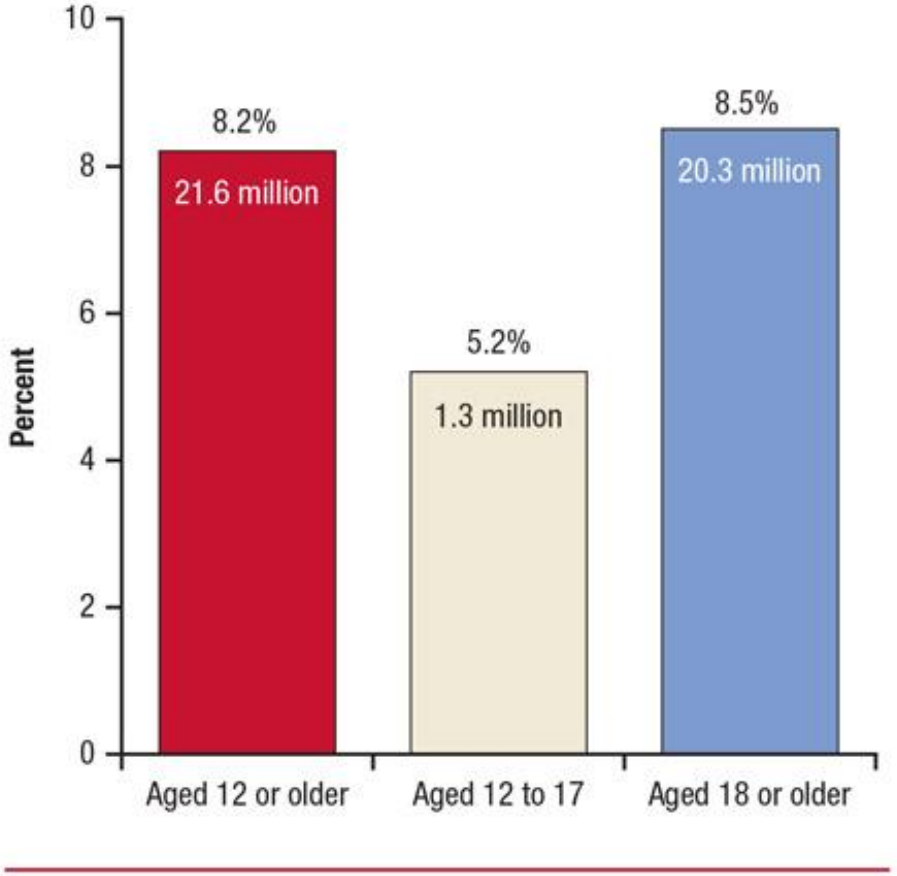
- Treat the psychiatric illness and the pain improves
- Treat the pain and the psychiatric illness improves



# Substance Use Disorders and Pain

# Substance Use Disorders and Pain

Substance use disorders in the past year among individuals aged 12 or older: 2013




Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2013.

# Substance Use Disorders and Pain

| Table 1. Illicit drug use in the past month among individuals aged 12 or older: 2013 | | | | | | |
|---|---|---|---|---|---|---|
| | Aged 12 or older | | Aged 12 to 17 | | Aged 18 or older | |
| Substance | Number (in thousands) | Percent | Number (in thousands) | Percent | Number (in thousands) | Percent |
| Illicit drug use | 24,573 | 9.4% | 2,197 | 8.8% | 22,376 | 9.4% |
| Marijuana and hashish | 19,810 | 7.5% | 1,762 | 7.1% | 18,048 | 7.6% |
| Cocaine | 1,549 | 0.6% | 43 | 0.2% | 1,505 | 0.6% |
| Inhalants | 496 | 0.2% | 121 | 0.5% | 375 | 0.2% |
| Hallucinogens | 1,333 | 0.5% | 154 | 0.6% | 1,179 | 0.5% |
| Heroin | 289 | 0.1% | 13 | 0.1% | 277 | 0.1% |
| Nonmedical use of prescription-type drugs | 6,484 | 2.5% | 549 | 2.2% | 5,935 | 2.5% |
| Pain relievers | 4,521 | 1.7% | 425 | 1.7% | 4,096 | 1.7% |

NOTE: Numbers and percentages do not sum to the illicit drug use estimate as individuals may have used more than one illicit drug. Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2013.

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4.5 million nonmedical users of prescription pain relievers (1.7% )

NOTE: Numbers and percentages do not sum to the illicit drug use estimate as individuals may have used more than one illicit drug. Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2013.

# Suicide and Chronic Pain

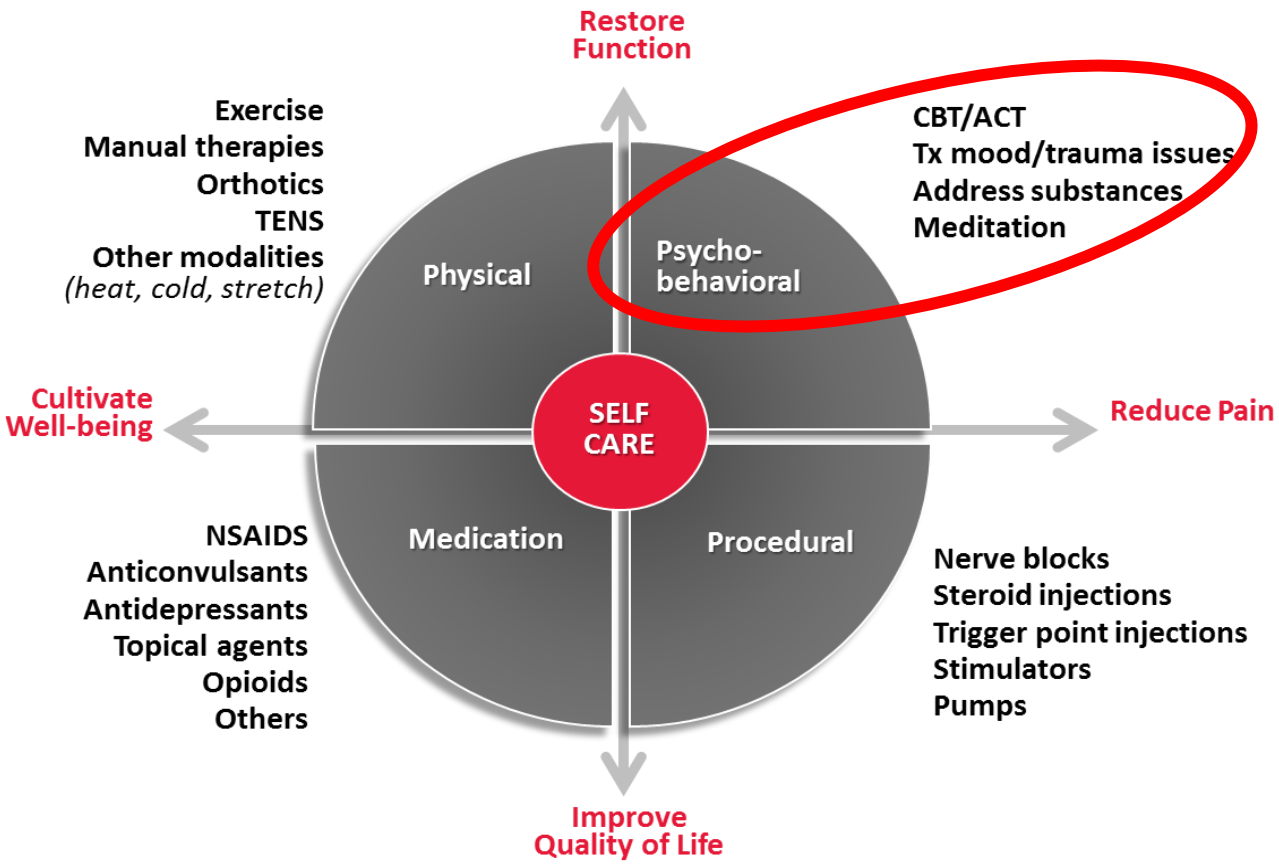
# Suicide and Chronic Pain

- Risk of death by suicide is approximately double in chronic pain patients
  - Those with co-occurring psychiatric illness at highest risk
- 5-14% lifetime prevalence of suicide attempts
- 20% lifetime prevalence of suicidal ideation
- Risk Factors
  - Helplessness and hopelessness about pain
  - Desire to escape from pain
  - Pain catastrophizing and avoidance
  - Problem solving deficits

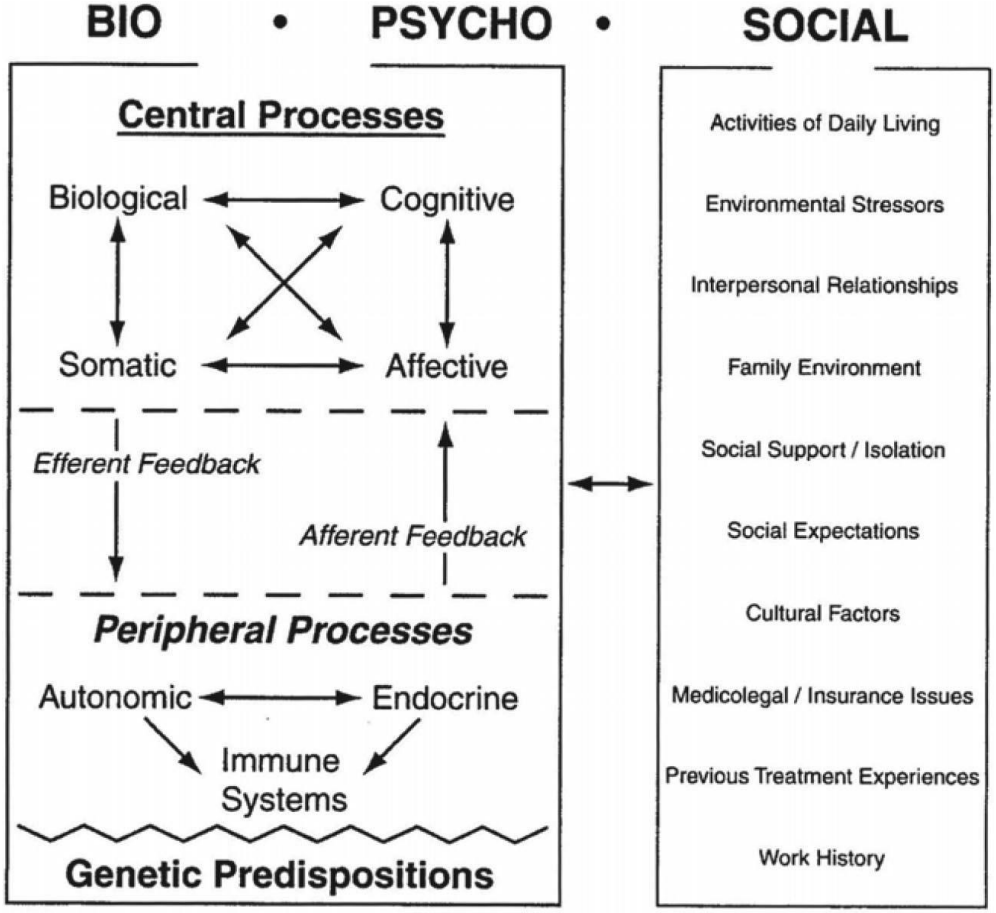
Tang et.al., Psychological Medicine, 2006, 36, 575–586

# Non-pharmacological Pain Treatment

# Non-pharmacological Pain Treatment



# Non-pharmacological Pain Treatment




- Biopsychosocial model
  - Perception of pain
  - Suffering – emotional response to pain
  - Pain behavior – things people say or do when suffering or in pain

Gatchel, RJ et.al, "The Biopsychosocial Approach to Chronic Pain: Scientific Advances and Future Directions" Psychological Bulletin. 2007, Vol. 133, No. 4, 581–624

# Non-pharmacological Pain Treatment

## Pain School Model

- Interdisciplinary team
  - Primary care provider: MD, APRN
  - Pain Psychologist
  - Clinical pharmacist
  - Rehabilitative staff: PT, OT, Rec therapy
  - Social worker
  - Nutritionist
- Shared Medical Appointments
  - Groups led by primary care and mental health specialists

# Non-pharmacological Pain Treatment

## Pain School Model

- Pain Self-Management
  - Minimize reliance on use medications
    - Base medication dosage on function
  - Promote of regular exercise and healthy and active lifestyle
  - Develop adaptive strategies for managing pain
  - Emphasize increasing functional goals and quality of life

# Non-pharmacological Pain Treatment

## Pain School Model

- Treatments
  - Evidence-based pharmacotherapy
  - Cognitive Behavioral Therapy
    - Address both pain and co-occurring psychiatric conditions (including SUD)
  - Graded Exercise Program
  - Relaxation Training

“Start where you are.
Use what you have.
Do what you can.”
-Arthur Ashe