Beyond The Stigma:

An Approach to Pain & Concurrent Addiction

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Strategies for Opioid Deimplementation in Primary Care

Monday, June 11, 2018

Toronto, Canada

afhto association of family health teams of ontario

Faculty/Presenter Disclosure

- Faculty: Andrew J Smith, MDCM
- Relationship with commercial interests
  - None

Mitigating Potential Bias

- Emphasis will be on published literature and guidelines.
- Clinical practices that lack evidence will be clearly stated to the audience.

Learning Objectives

By the end of the session, participants will be able to:

1. Outline an approach to managing pain in patients with a substance use disorder
2. List 4 characteristics of addiction
3. Outline an approach to tapering opioids

Chronic Pain Defined

- IASP (1986): ***an unpleasant sensory and emotional experience associated with actual or potential tissue damage***
- Acute pain is a vital, protective mechanism that permits us to live in an environment fraught with potential dangers
- In contrast, chronic pain serves no such physiologic role and is itself not a symptom, but a disease state
- Chronic = pain which lasts beyond the ordinary duration of time that an insult or injury to the body needs to heal
  - Beyond 3-6 months in duration

IASP- International Association for the Study of Pain

Question

What percentage of North Americans are currently experiencing pain which has gone on for more than 6 months?

1. 2%
2. 5%
3. 10%
4. 25%

Chronic Pain is Common

- Prevalence of chronic pain in the adult population may be 30% (Moulin et al 2001)
- 18% of Canadian adults suffer from moderate to severe chronic pain daily or most days of the week (Nanos Survey 2007-2008)
- Most common reason for visit to family physician (~ 20-25%)
- **Chronic pain is unlikely to completely resolve (30% reduction is a GOOD outcome)**

Opioids have long been used to manage pain, especially in acute and palliative contexts

Question

What percentage of Ontario middle and high school students (Gr 7-12) used opiates for non-medical purposes in the past year?

1. 5%
2. 7%
3. 10%
4. 15%

OSDUHS 2017
Past Year Use – Top 10

Alcohol	42.5.8% (66.0 %)
Cannabis	19.0% (28.0 %)
Binge Drinking (5+ drinks at a time in past month)	16.9 % (27.6 %)
Vape pens (e-cigarettes)	10.7% (n/a)
Opioid Pain Relievers (NM)	10.6% (20.6 %)
OTC Cough/Cold Medication	9.2 % (n/a)
Cigarettes Tobacco	7.0 % (28.4 %)
Inhalants (Glue or solvents)	3.4 % (8.9 %)
Hallucinogens other than LSD, PCP	3.4% (7.9 %)
Stimulants (NM)	2.1 % (6.8 %)
Synthetic cannabis ("Spice," "K2)	1.5 % (n/a)

OSDUHS - Ontario Student Drug Use and Health Survey

(www.camh.net)

Some Pearls…

- Chronic pain is treatable
- Many causes --> assess thoroughly
- Attend to risk
- Attend to co-morbidities
- 3 Ps of Pain Treatment: Pharm, Psychological, Physical
- Tapering improves outcomes
- Outcomes: Function, QoL, Pain
- The right to effective pain management is not equal to a right to be prescribed opioids
- Treat pain in patients with substance use disorders

ADDOP: The Five Pillars of Pain Management

- **Assess: Symptoms and Risk**
- **Define the problem: where and what is it?**
- **Diagnose the kind of pain and treat it**
- **Other issues: mood, anxiety, sleep, addiction, sex**
- **Personal management, self management**

Gordon A. Pain Manag. 2012 Jul;2(4):335-44.

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Pillar 1: Assessment

General history

- COPD, Sleep apnea
- CKD
- Elderly
- Falls

Neurological history

Pain history

Risk history

Pillar 1: Assessment

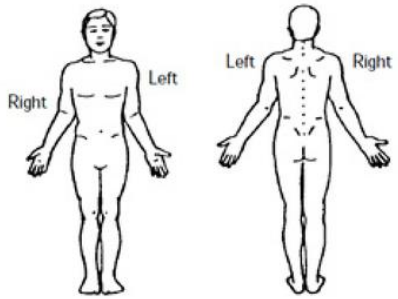
Date: ____ /____ /____ Time: _____

Name: _____ _____ _____
Last First Middle intial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its **worst** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain — Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its **least** in the past 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No pain — Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on **average**.

0 1 2 3 4 5 6 7 8 9 10
No pain — Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have **right now**.

0 1 2 3 4 5 6 7 8 9 10
No pain — Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

_____

_____

8) In the past 24 hours, how much **relief** have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0% 10 20 30 40 50 60 70 80 90 100%
No relief — Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has **interfered** with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

D. Normal work (includes both work outside the home and housework)

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

F. Sleep

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

G. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

Pillar 1: Risk Assessment

“Universal Precautions” history

- Aberrant drug-related behaviours
- **Personal history of problematic drug/alcohol use**
- **Family history of problematic drug/alcohol use**
- **Affective disorders**
- **Childhood abuse / adversity**
- **PTSD**
- Urinary drug screen and identification

- Identify the individuals with the greatest risk of aberrant behaviour NOT to stigmatize, but to improve care

Opioid Risk Tool

Mark each box that applies	Female	Male
1. Family hx of substance abuse		
Alcohol	☐ 1	☐ 3
Illegal Drugs	☐ 2	☐ 3
Prescription drugs	☐ 4	☐ 4
2. Personal hx of substance abuse		
Alcohol	☐ 3	☐ 3
Illegal Drugs	☐ 4	☐ 4
Prescription drugs	☐ 5	☐ 5
3. Personal hx of substance abuse	☐ 1	☐ 1
4. Hx of preadolescent sexual abuse	☐ 3	☐ 0
5. Psychologic disease		
ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
Scoring totals:		

<u>Administration</u>

- On initial visit
- Prior to prescribing

<u>Scoring</u>

- 0 – 3 low risk
- 4 – 7 moderate risk
- 8+ HIGH RISK

ORT demonstrated high sensitivity and specificity for detecting individuals presenting to a pain clinic at risk for developing aberrant behaviors around use of opioids

A personal history of abuse of illicit drugs or alcohol remains the strongest predictor of opioid misuse and abuse

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Webster et al. Pain Med 2005; 6: 432

Aberrant Drug Related Behaviours

- Selling medications / RX Forgery
- “Street” sourcing
- Crushing / Snorting / Injecting
- Multiple dose-escalations or other non-compliance with therapy despite discussions
- Multiple episodes of prescription loss or theft
- Double doctoring
- Functional deterioration seemingly related to drug use
- Repeated resistance to change in therapy despite clear evidence of therapeutic failure or adverse effect

Addiction (5Cs)

- "A primary, **chronic**, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations.
- It is characterized by behaviors that include one or more of the following:
  - **Control** impaired over drug use
  - **Compulsive** use
  - **Continued** use despite harm
  - **Cravings**"

American Society of Addiction Medicine. Public Policy Statement: Definition of Addiction. 2011. http://www.asam.org/DefinitionofAddiction-LongVersion.html

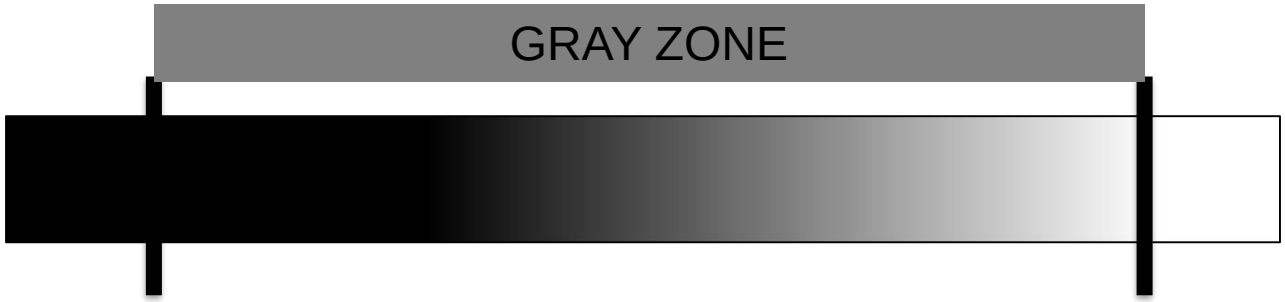
Criteria Suggestive of ADRBs or Use D/O in Pain Patients

ASAM-APS-AAPM BEHAVIORAL CRITERIA	EXAMPLES OF SPECIFIC BEHAVIORS IN OPIOID THERAPY OF PAIN
Impaired control over use, compulsive use	Frequent loss/theft reported, calls for early renewals, withdrawal noted at appointments
Continued use despite harm due to use	Declining function, intoxication, persistent over-sedation
Preoccupation with use, craving	Nonopioid interventions ignored, recurrent requests for opioid increase/complaints of increasing pain in absence of disease progression despite titration

DSM-V Diagnostic Criteria for Substance Use Disorder (2013 →

- Tolerance*
- Withdrawal*
- More use than intended
- Craving for the substance
- Unsuccessful efforts to cut down
- Spends excessive time in acquisition
- Activities given up because of use
- Uses despite negative effects
- Failure to fulfill major role obligations
- Recurrent use in hazardous situations
- Continued use despite consistent social or interpersonal problems

*not counted if prescribed by a physician



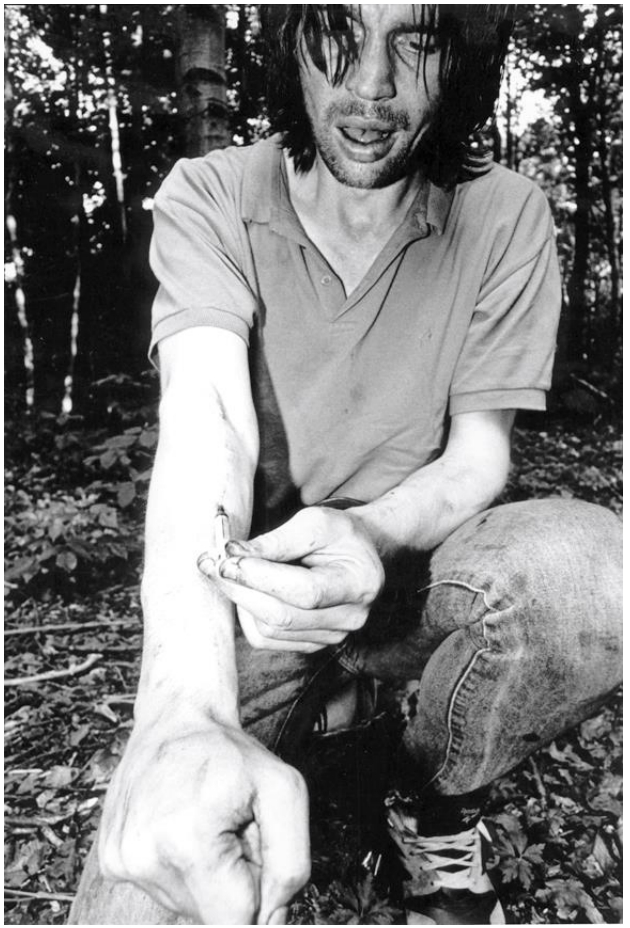
ADDICTED

Meets DSM criteria
for addiction

NOT ADDICTED

- No lost prescriptions
- No ER visits
- No early prescriptions
- No requests for dose escalation
- No UDT aberrancies
- No doctor shopping (PMP)

Dependence on Opioid Pain Medications



- Nobody wants to call it addiction
- It often doesn't look like "addiction"
- It is pathological
- It does destroy lives
- It is avoidable, and it is treatable

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Pillar 2: Define the Underlying Problem

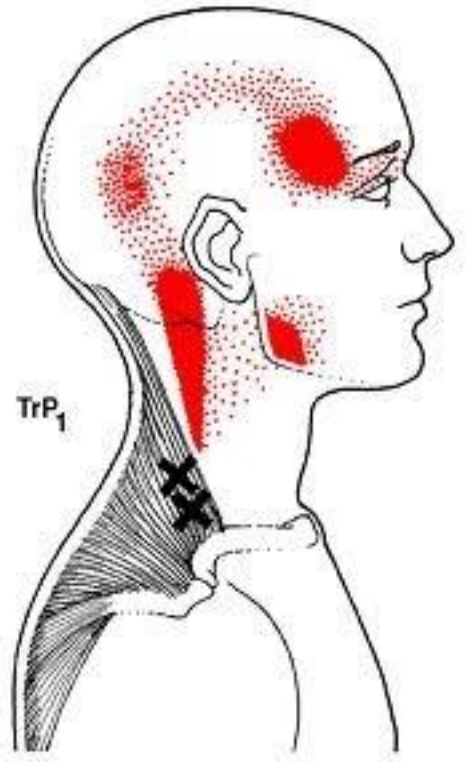
- General, MSK and neurological exam
- Investigation

  Neurophysiological testing: EMG/NCT and possibly evoked response

  Pain scales including BPI and DN4, S-LANNS

  Neuroimaging

- Where is the lesion and what is the lesion?
- Applies to neurological conditions and non-neurological conditions
- Treating underlying disease sometimes helps reduce pain



Pillar 3: Diagnose Pain and Treat Rationally

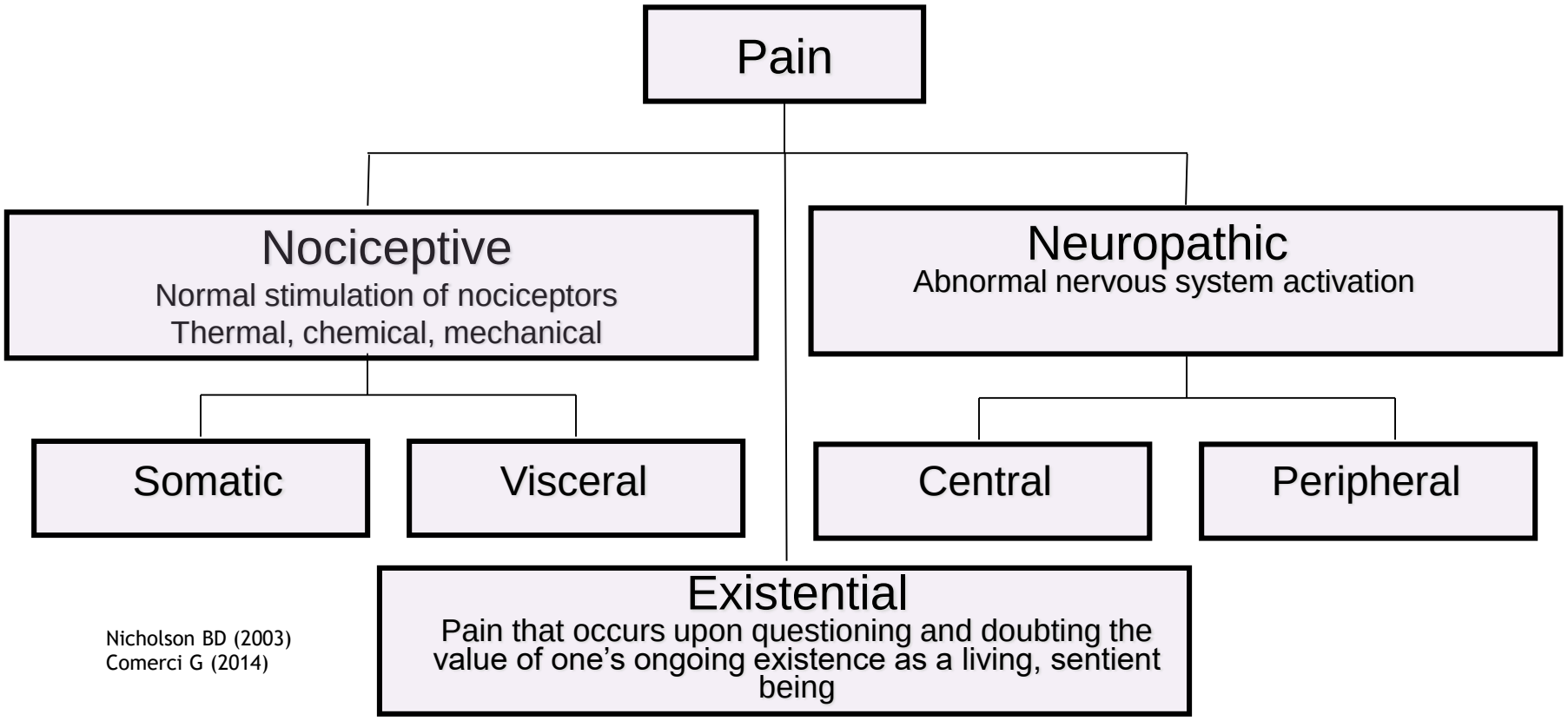
Nociceptive vs Neuropathic

Cancer vs Non-Cancer

Acute vs Chronic

Mild, Moderate and Severe

Pillar 3: Diagnose Pain and Treat Rationally



Nicholson BD (2003)
Comerci G (2014)

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Pillar 4: Co-Morbidities

- Pain
- Mood/Anxiety
  - Use PHQ-9, GAD-7 tools
- Sleep
- Substances
- And then some….
  - Chronic renal disease
  - Liver disease
  - Iatrogenic

Chronic Pain - Comorbidities

Associated with the worst quality of life when compared with other chronic diseases such as chronic cardiovascular or respiratory diseases (Jovey et al. 2010)

Mood and anxiety disorders are 2 – 7 x more prevalent in populations of chronic pain and migraine patients in primary, specialty and tertiary care samples (Tunks et al 2008)

Co-morbidities multiply functional compromise and QOL restrictions with pain (NB: OUTCOMES)

Suicide risk 2x higher in CP population vs the non-pain population (Tang, 2006)

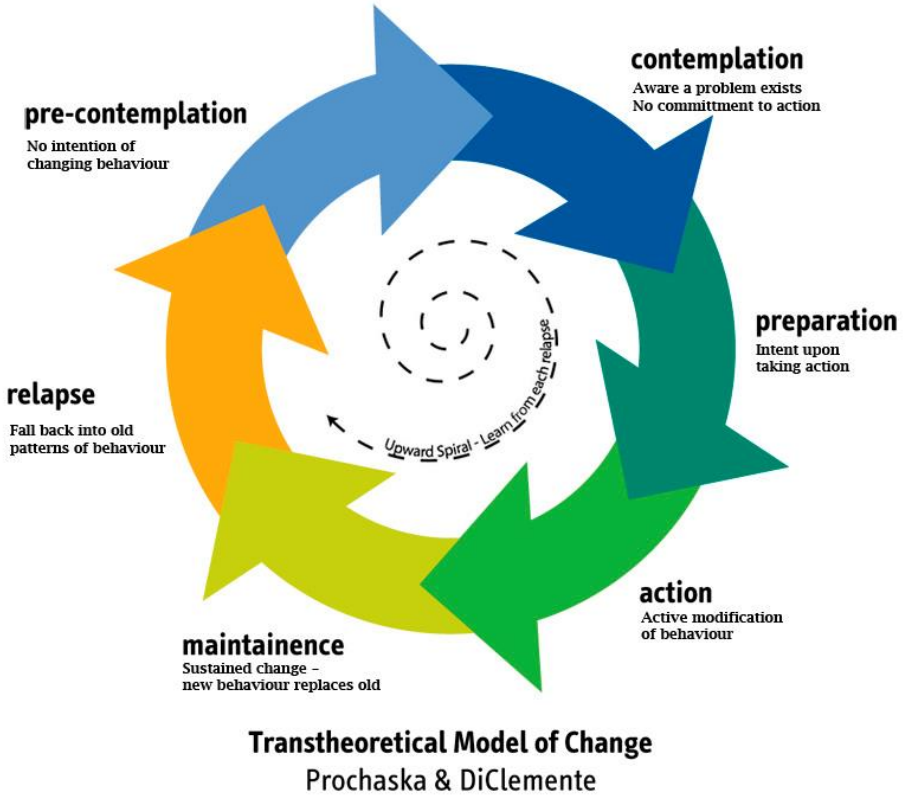
Substance use disorder among patients with chronic pain: 2-14%

Pain as a Motivational Disorder

- A daily reminder of derailment
- Traumatic
- Robs assertiveness
- A neurological signal to cease and desist
- Multifactorial – multiple concurrent disorders
- Overwhelming
- Isolating

Pillar 5: Personal Responsibility and Self-Management

- Who's working harder?
- Lack of buy-in and self management is likely a key component of the 'refractory' patient
- Proactive management of realistic expectations
- Need to educate patient and family about pain management techniques
- Therapeutic alliance is key
- Clinicians need to practice (not just talk about) interprofessional model
  - Lack of prompt recovery → we tend to repeatedly apply medical model – more consults, tests, drugs
  - Other modalities – psychological and otherwise – are left out



Stages of Change – Where's the Patient?

Meet them where they are

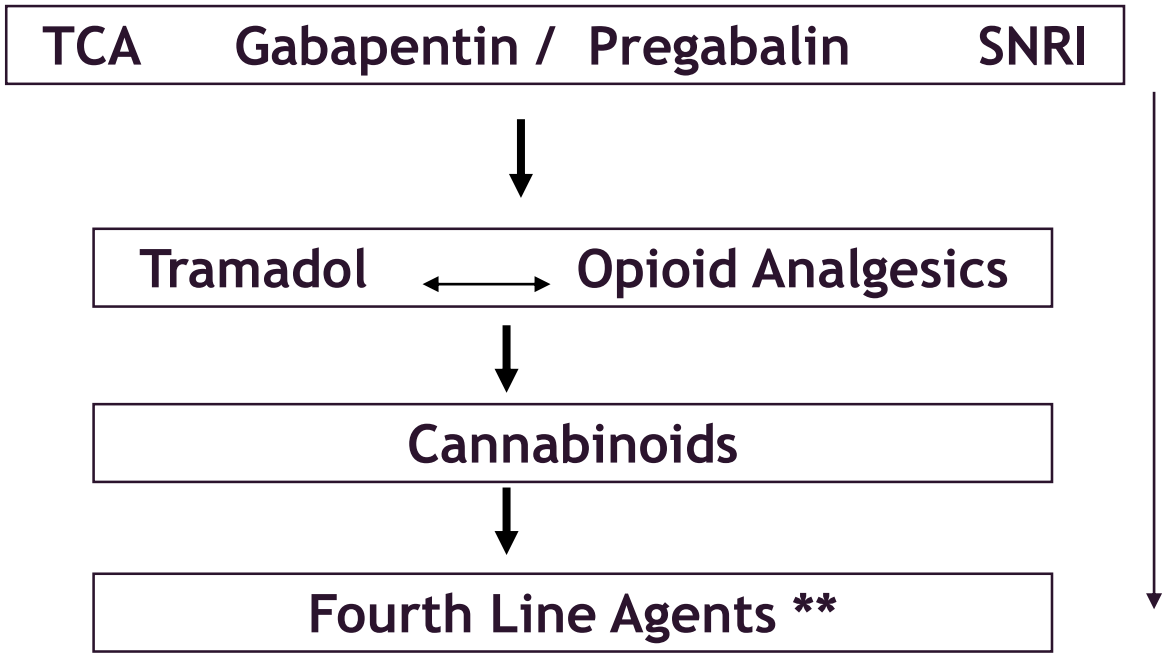
Continuum of ambivalence

Explore readiness to change, importance and confidence

Non-pharmacologic therapy – 3 Ps

- Self-Management
- Cognitive and Behavioural Therapy (CBT)
- Meditation
- Mindfulness techniques
- Exercise
- Physical therapy
- Interventional approaches: nerve stimulation or block
- Acupuncture
- Botox
- **ETC…**

Pharmacologic Steps in Neuropathic Pain



Add additional agents sequentially if partial but inadequate pain relief***

** eg SSRIs, methadone, lamotrigine, topiramate, valproic acid

*** Do not add SNRI to TCA

Moulin DE et al. Pain Res Manag. 2014

GUIDELINE CPD

Guideline for opioid therapy and chronic noncancer pain

Jason W. Busse DC PhD, Samantha Craigie MSc, David N. Juurlink MD PhD, D. Norman Buckley MD, Li Wang PhD, Rachel J. Couban MA MISt, Thomas Agoritsas MD PhD, Elie A. Akl MD PhD, Alonso Carrasco-Labra DDS MSc, Lynn Cooper BES, Chris Cull, Bruno R. da Costa PT PhD, Joseph W. Frank MD MPH, Gus Grant AB LLB MD, Alfonso Iorio MD PhD, Navindra Persaud MD MSc, Sol Stern MD, Peter Tugwell MD MSc, Per Olav Vandvik MD PhD, Gordon H. Guyatt MD MSc

Cite as: *CMAJ* 2017 May 8;189:E659-66. doi: 10.1503/cmaj.170363

CMAJ podcasts: author interview at https://soundcloud.com/cmajpodcasts/170363-guide

See related article www.cmaj.ca/lookup/doi/10.1503/cmaj.170431

"We suggest avoiding opioid therapy for patients with a history of substance use disorder (including alcohol) or active mental illness, and opioid therapy should be avoided in cases of active substance use disorder."

Opioid Tapering

- Discuss benefits of tapering, that pain and function will improve
- Share success stories
- Normalize apprehension and provide support and frequent follow-up
- Provide patient with naloxone kit
- Provide harm reduction education
- Dispense opioids frequently in small quantities (as often as daily)
- Taper by 10% every 2-4 weeks…May slow down when < 50% of original dose
- Consider opioid rotation if patient gets stuck
- Consider Suboxone if patient gets stuck
- Never reverse course
- Frequent follow up (every 1-2 weeks)

Managing Pain in Patients with OUD or at Risk

- Methadone
- Buprenorphine
- Acute-on-chronic short-acting opioids
  - Structured (dispensing, visits, UDTs)
  - Don’t use drug of choice
- Non-opioid adjuvants
- Interventional modalities
- Non-pharm modalities

NOUGG Guidelines 2010
CLUSTER 5: Managing Opioid Misuse and Addiction

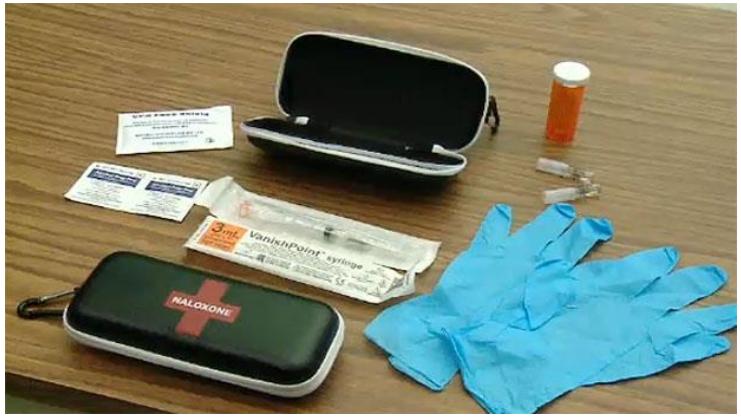
For patients with chronic non-cancer pain who are addicted to opioids, three treatment options should be considered:

1. Methadone or buprenorphine treatment (Grade A)
2. Structured opioid therapy (Grade B), or
3. Abstinence-based treatment (Grade C)

Consultation or shared care, where available, can assist in selecting and implementing the best treatment option (Grade C)

Take-Home Naloxone

- Competitive opioid antagonist with duration of action: 15-30 mins
- 2 bioequivalent formulation: parenteral 0.4mg and intranasal 4mg



INDICATIONS

- On a high dose of prescription opioids (200+ mg MED)
- On prescription opioids and also taking benzodiazepines or drinking heavily.
- Previous overdose
- Suspected OUD
- Intermittent recreational use or illicit opioids
- Has regular contact with friends or relatives who have OUD
- Heavy users of cocaine or other non-opioid drugs (drug dealers sometimes add fentanyl to non-opioid drugs)

Structured Opioid Therapy

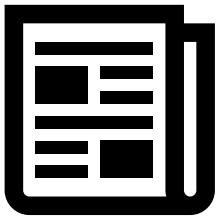
- Continued opioid prescribing under conditions that limit aberrant drug related behaviours
- Effective, convenient and easier to organize than opioid substitution therapy

INDICATIONS

- Has or is at **high risk for opioid use disorder** (younger, personal or strong family history of addiction, anxiety or mood disorder)
- Has **pain condition requiring opioid therapy**
- **Only uses opioids supplied by one physician**
- **Does not alter route of delivery** (inject or crush oral tabs)
- Is **not currently addicted to alcohol or other drugs**

PROTOCOL

- Dispense small amounts frequently (e.g., 1–2 times per week)
- Do not refill if patient runs out early
- Monitor closely with urine drug screens, pill counts, office visits
- Treatment agreement
- Switch to buprenorphine or methadone treatment if structured opioid therapy fails (e.g., patient continues to access opioids from other sources)



Involuntary Tapering

Opioid tapering is often difficult for people with moderate-severe OUD

- Intense and frightening withdrawal symptoms
- Powerful cravings
- Access illicit opioids

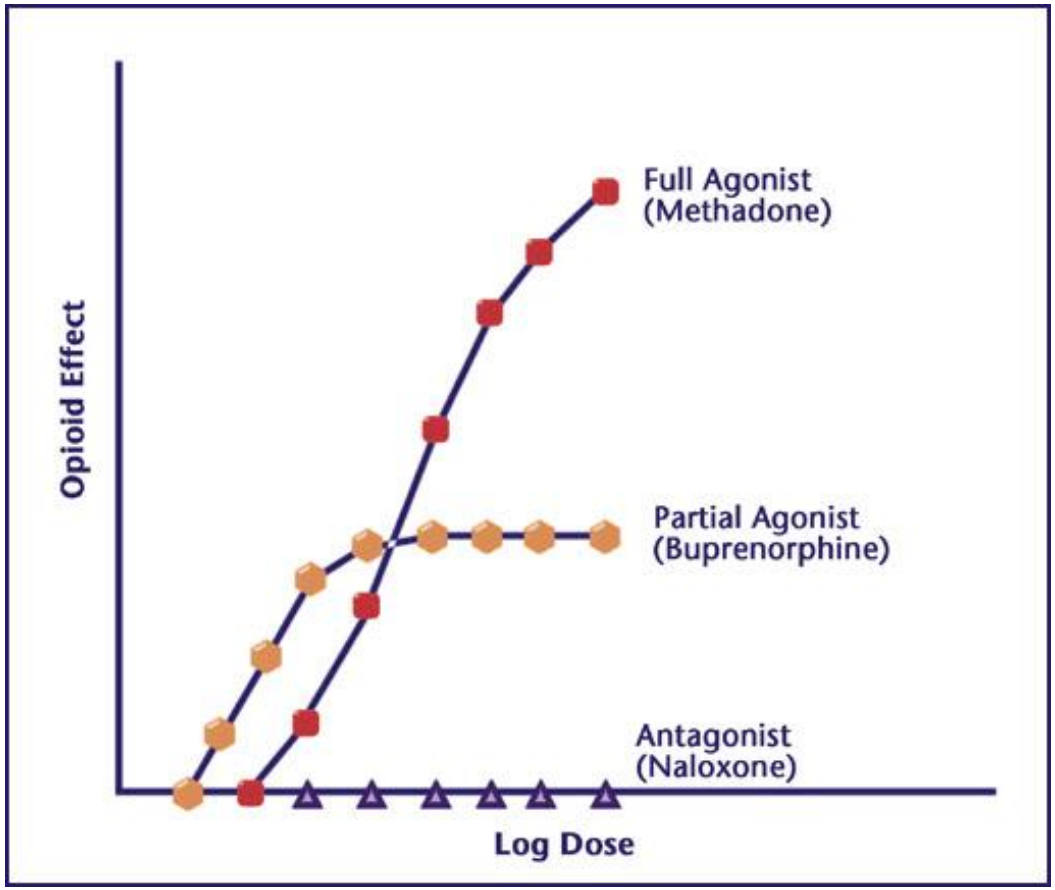
Methadone or Buprenorphine/naloxone is indicated in these cases, but they may be resistant to treatment

Tapering gives patients several weeks or months to consider and make informed decision for opioid maintenance therapy

Safer to patient and to public than ongoing prescribing of high doses of opioids or abrupt cessation (NB risk of overdose)

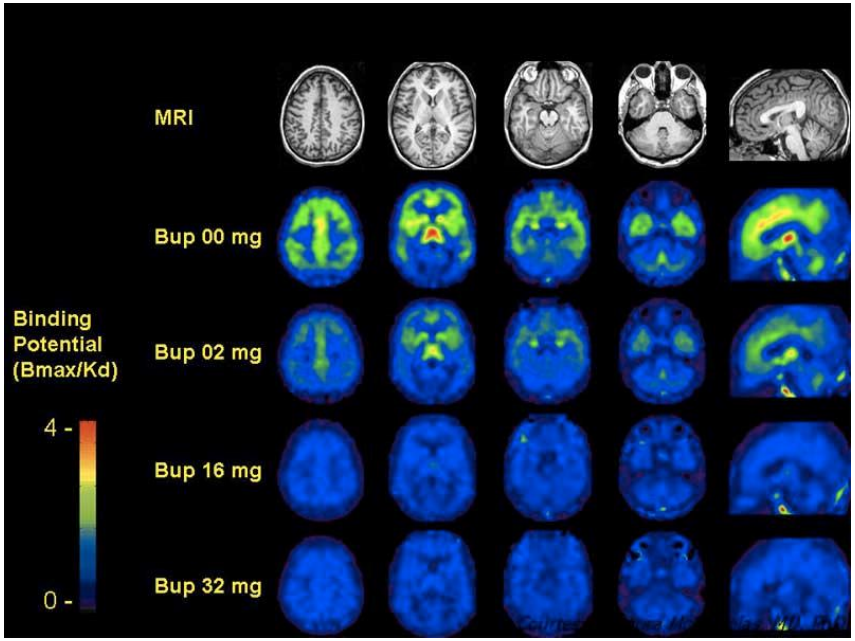
Buprenorphine

- Partial opioid agonist
- Ceiling effect



Partial Agonist ?

- Morphine also produces <100% effect
- Bup acts at multiple receptors → total analgesic effect results from activity at several receptors
- Bup displays > 98% noci efficacy in animal models
- PET scans of human brains show that full analgesia achieved with bup doses that occupy < 100% of opioid receptors



Raffa et al. J. Clin Pharm and Therapeutics. 2014

Potential Advantages of Buprenorphine in Chronic Pain

- Efficacy demonstrated in various pain conditions, comparable to “full agonists”
- Ceiling effect for respiratory depression
- Less development of tolerance via KAPPA antagonism, ORL agonism
- Antihyperalgesic effect (Na channel action)
- Less effect on hypogonadism (ORT experience)
- Less immunosuppression compared with morphine and fentanyl (limited evidence – preclinical and clinical)
- Ease of use un elderly and in renal impairment
- ? Efficacy in neuropathic pain

Opioid Strategy - PREVENTION: Pain management

- **Enhance access to non-opioid and non-pharmacological treatment options for pain** *>>> provincial government*
  - Investing $17 million annually in Ontario's Chronic Pain Network to create or enhance 17 chronic pain clinics across the province, ensuring that patients receive timely and appropriate care
- **Improve pain management & addiction education** *>>> provincial*
  - Address pain management in people with mental illness, substance use issues, trauma
  - ECHO
  - MMAP (supports primary care physicians by providing case-by-case support and ongoing mentorship in pain, addictions and mental health)
  - Academic Detailing (targeted one-on-one and group educational interventions for high opioid prescribers) – CEP
  - Entry to Practice - Medical School and Residency Curriculum (ECHO)
  - And much more… CAMH Opioid Prescribing Course, etc
- Establish a research focus aimed at improving the state of evidence for chronic pain management *>>> federal*
- Develop a National Pain Strategy *>>> federal*

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Thank You!