Pain and Addiction

Module 11

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Disclosure

MI-CCSI, or the presenter, does not have any financial interest, relationships, or other potential conflicts, with respect to the material which will be covered in this presentation.

Patient-Centered Treatment for Substance Use Disorder in Primary Care

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Clinical

Module	Title
1	Navigating Buprenorphine Prescribing for the Primary Care Physician
3	Buprenorphine Medical Management: Monitoring the Patient
5	Challenging Clinical Scenarios in MOUD: Early Refills and Lost or Stolen Medication
7	Complex Cases in Buprenorphine Treatment, Part 1
9	Complex Cases in Buprenorphine Treatment, Part 2
11	Pain and Addiction

Operational

Module	Title
2	Substance Use Disorder and Patient Identification
4	OBAT Eligibility, Intake and Assessment
6	Patient Support for Induction and Maintenance
8	Operationalizing Team Meetings, Systematic Case Review, & Documentation
10	Team Roles and Responsibilities
12	Supporting the Patient Beyond Buprenorphine

Action Period Assignment

From Module # 9

- **We discussed today two high risk cases today with two very different treatment approaches. One involved prescribing buprenorphine in a high-risk situation, and other involved not providing buprenorphine under similar circumstances.**
  - **Prior to this presentation, what was your opinion of providing buprenorphine in the context of active substance use, and did these cases change your viewpoint? Why or why not?**
- **Some clinics have very stern controlled substance agreements, which stipulate that ANY drug use outside of what is prescribed may result in dismissal from the clinic.**
  - **While we have discussed the clear disadvantages to this approach, can you think of any advantages to taking this type stance?**

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OBJECTIVES

At the conclusion of this presentation, the participant will be able to:

- **Apply concepts learned to individual cases including parameters to consider when evaluating whether buprenorphine is appropriate for a given patient.**
- **Recognize psychogenic pain syndromes and associated clinical implications.**
- **Understand the pain-addiction triangle**

AGENDA

1	Case Study
2	Psychogenic Pain Syndromes
3	The Pain-Addiction Triangle

Case Study

Case Study

- 43-year-old female with a history chronic lower back pain presents to your clinic for ongoing care. She has experienced pain difficulties since the age of 22 and is now unemployed and receiving disability benefits. She has a history of depression, anxiety, and chronic insomnia.
- Her pain is rated an 8/10, and she reports “nothing works.” Additionally, she continues to report significant mental health difficulties.
- The patient is prescribed
  - Vicodin (5/500) 1-2 tabs every 6 hours
  - MS Contin 30 mg twice daily
  - Zoloft 100 mg daily
  - Gabapentin 600 mg three times daily.
  - Ativan 0.5 – 1 mg qhs, PRN

Case Study (Continued)

- The patient sees a psychiatrist every 3 months for “fifteen minutes.”
- She reports chronic difficulty with depression and anxiety and describes that her psychiatric medications “do nothing.”
- She continues to report high pain scores, which are inconsistent with her general appearance.
- She is requesting a dosage increase or a medication change.
- UDS shows THC, which the patient reports helps with pain and is also used for sleep.
- MAPS report does not reveal any concerns.

Case Study (Continued)

- She reports a history of a fall 20 years ago, and recurring “back injuries,” but there is no evidence of orthopedic trauma.
- Past med trials include “everything,” including oxycodone, fentanyl, methadone, pregabalin, and multiple “muscle relaxers.”
- She grew up in northern Michigan, parents divorced when she was 12 and described her father as “a raging alcoholic.” She’s single and has two adult children.

What other information do you want to know?

Case Study (Continued)

This case deserves a detailed social history:

- Where did you grow up?
- What was it like growing up?
- Are there any memories you wish you could forget but you can't?
- Has anyone ever touched you in a way that made you feel uncomfortable?
- Are you facing any type of legal trouble? Would you feel comfortable sharing the details with me?
- Are you currently employed? How is that going?
- Are you in a relationship of any kind? How is that going?

Case Study (Continued)

A detailed social history can help you with:

- Uncovering past traumatic experiences which may be manifesting as PTSD, other psychiatric difficulties, and pain syndromes (discussed later).
- Determining a vulnerability to addiction
- Identifying signs and symptoms of addiction, including relationship discord, employment struggles, family turmoil, and potential legal problems.
- Establishing good rapport with a patient, which is essential in challenging cases.
  - (When done appropriately, inquiring on a patient's social history shows interest, which is positively perceived by patients)

Case Study (Continued)

The patient reported the following history:

- Her father physically abusing her mother.
- “Sexual assault” at the age of 15 by a “family friend”.
- Emotional abuse perpetrated by her ex-boyfriend (father of her children).
- No legal problems.
- Unemployed, receiving disability benefits for “many reasons.”
- No other relevant social history.

What else would you like to know?

Case Study (Continued)

- Patient is modestly demanding about a medication change or dosage increase.
- There is no evidence of misuse in the patient's medical record.
- Refills have been methodically timely.

QUESTIONS:

- Does this patient have a substance use disorder?
- Does this patient's pain syndrome necessitate opioids?
- Is buprenorphine an appropriate treatment option?

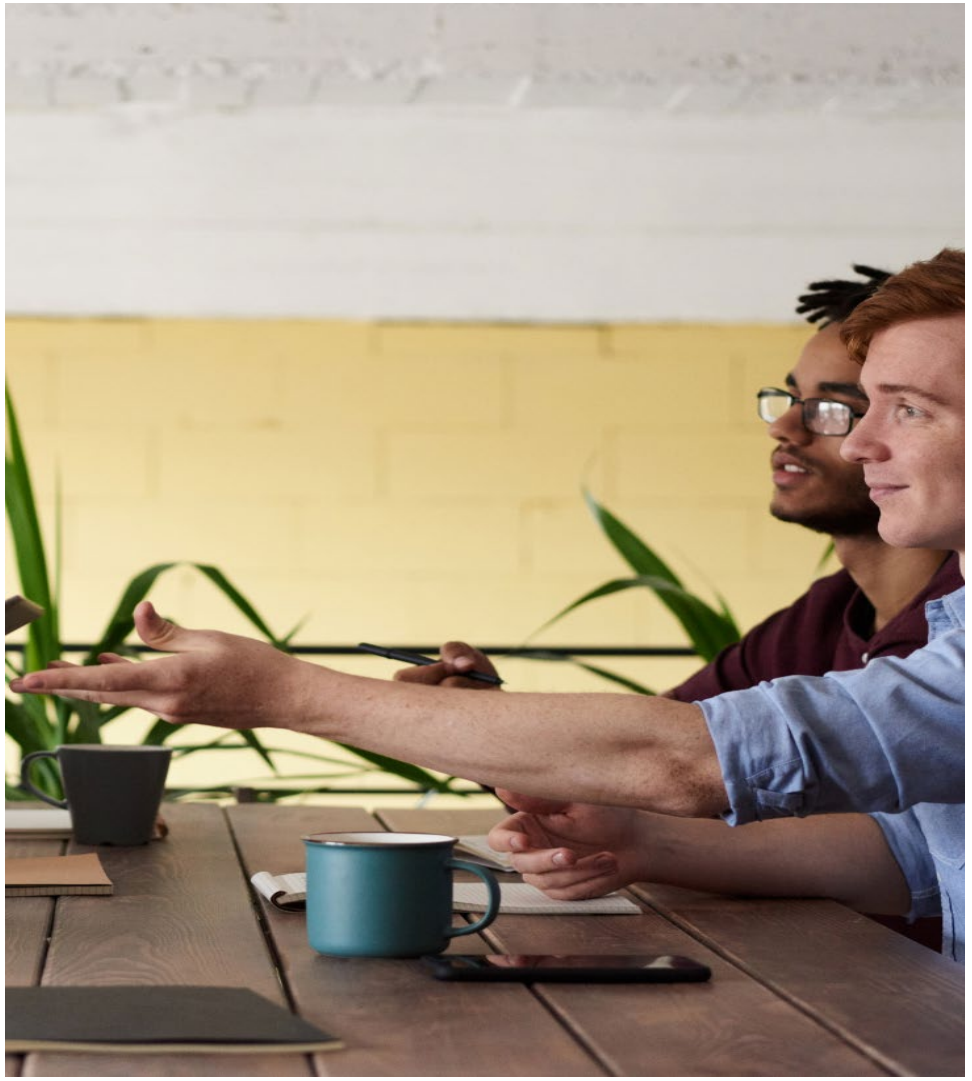
Case Study (Continued)

Reasons to use buprenorphine:

- Off-label for chronic pain management (pain without addiction).
- Opioid maintenance therapy for OUD (addiction with or without pain).
- A bridge to wean the patient off opioids.

Reasons NOT to use buprenorphine:

- This may not be an organic pain syndrome.
- The patient may have pain but is not a candidate for opioid pharmacotherapy (buprenorphine is an opioid).



Some take away points …

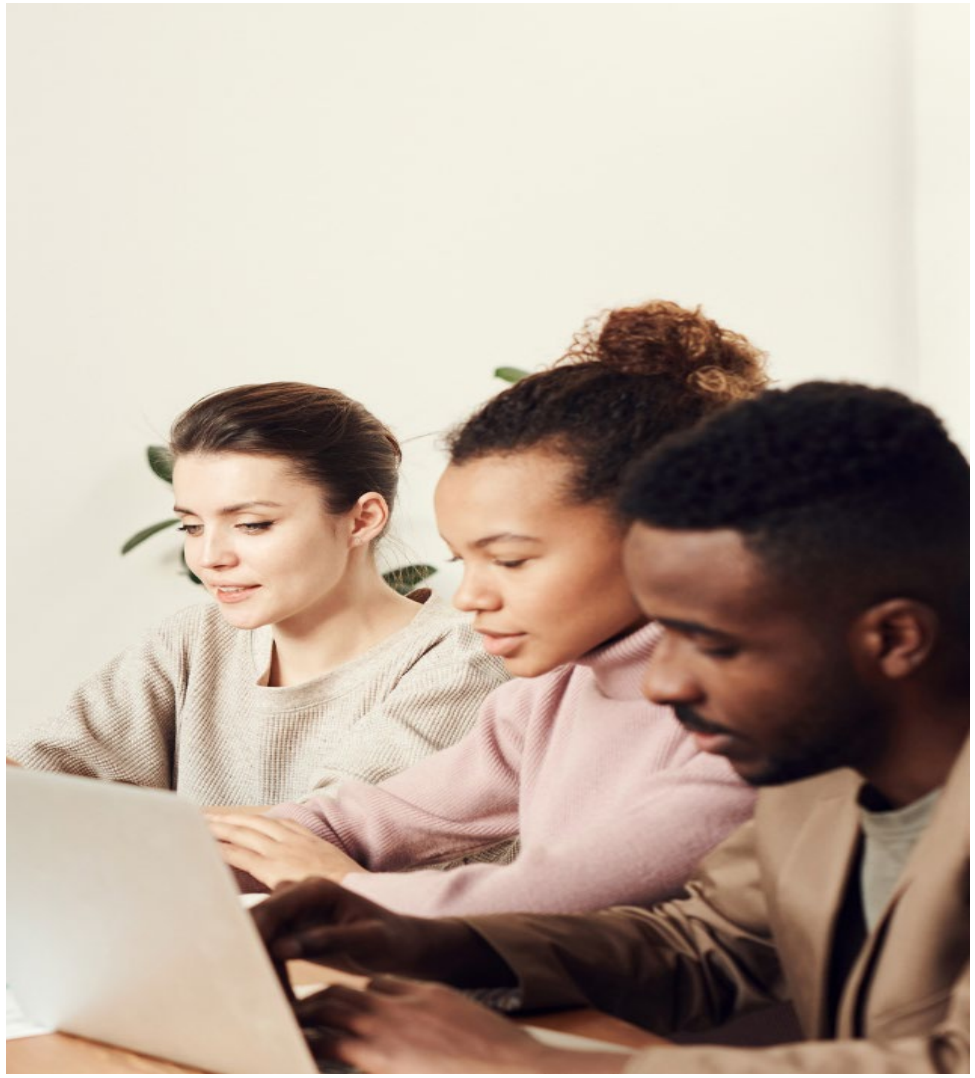
- Diagnoses and treatment planning are a long-term conversation – you will NOT figure this out in one visit.
- At times, addiction is subtle and can fool you:
  - *What doesn't seem to be addiction is addiction, and what looks like addiction may not be addiction.*
- It's reasonable to continue an opioid medication regiment (as long as there is no evidence of misuse) while you sort out your clinical impression.
- **Giving more of what is not working is not logical.**

Psychogenic Pain Syndromes

Chronic Pain - definitions

- Chronic pain is defined by the International Association for the Study of Pain as ‘‘pain that persists beyond normal tissue healing time, which is assumed to be three months.”
- All chronic pain disorders outside of cancer pain or pain at end of life are collectively labeled ‘‘chronic non-cancer pain’’.

Common Chronic Pain Conditions



- Fibromyalgia
- Osteoarthritis
- Headaches
- Chronic back pain
- Psychogenic pain syndromes ***

Psychogenic Pain Syndromes

- Physical/sexual abuse causing chronic pain.
- This area is poorly studied, and quality literature with good treatment outcomes is lacking.
- Adults who have been sexually abused appear at disproportionately high risk of conditions such as:
  - Irritable bowel syndrome
  - Non-epileptic seizures
  - Chronic fatigue syndrome
  - Chronic pelvic pain and other chronic pain syndromes
  - Fibromyalgia

What is being offered as a treatment?

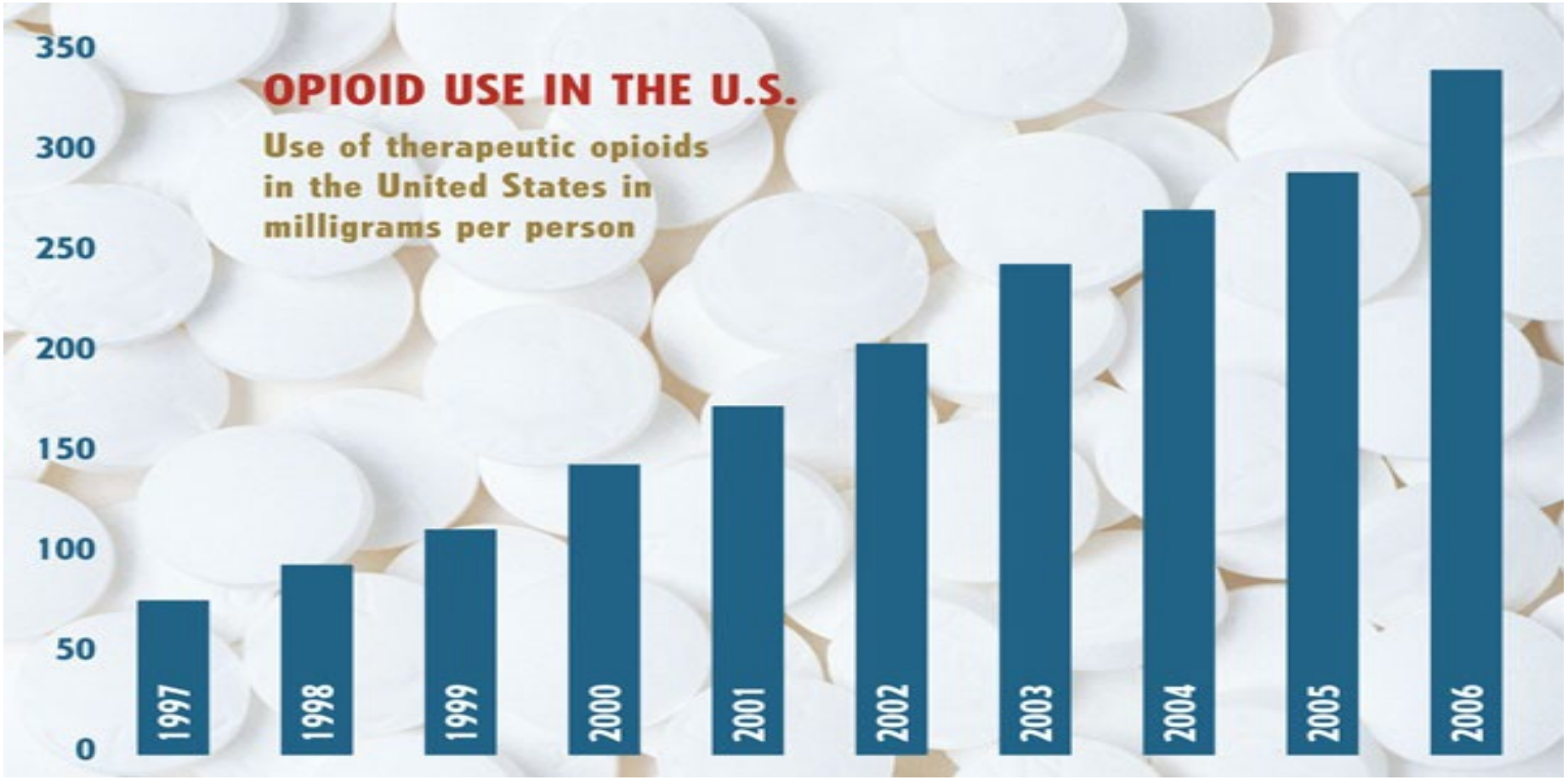
- Even in cases of pain emanating from psychological causes, OPIATES are often utilized.
- Because the underlying etiology is not being addressed, patients will often continue to report disability and chronic pain.
- **The use of opiates will produce a positive reinforcing effect, in some patients, which will mitigate underlying mood and anxiety difficulties.**

Opioids are DANGEROUS

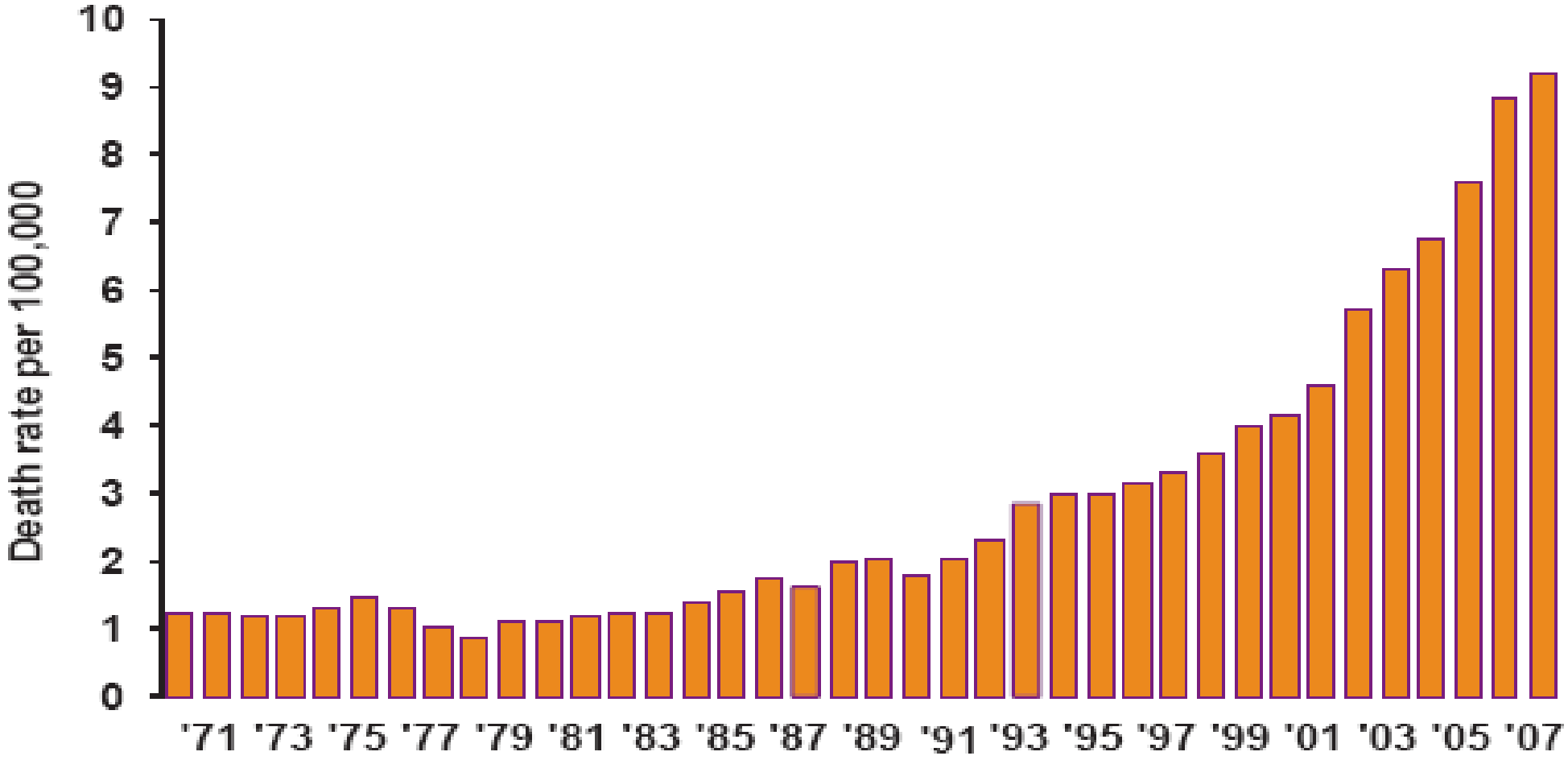
- Overuse results in respiratory depression.
- Highly addictive nature of these drugs drives over-use and may lead to overdose and death.

Trends in Opiate Prescribing

The use of therapeutic opioids-natural opiates and synthetic versions-increased 347% between 1997 and 2006, according to this U.S. DEA data.



Rate of Unintentional Drug Overdose Deaths in US 1970 - 2007



Why has this become such a problem?

We weren't prepared…

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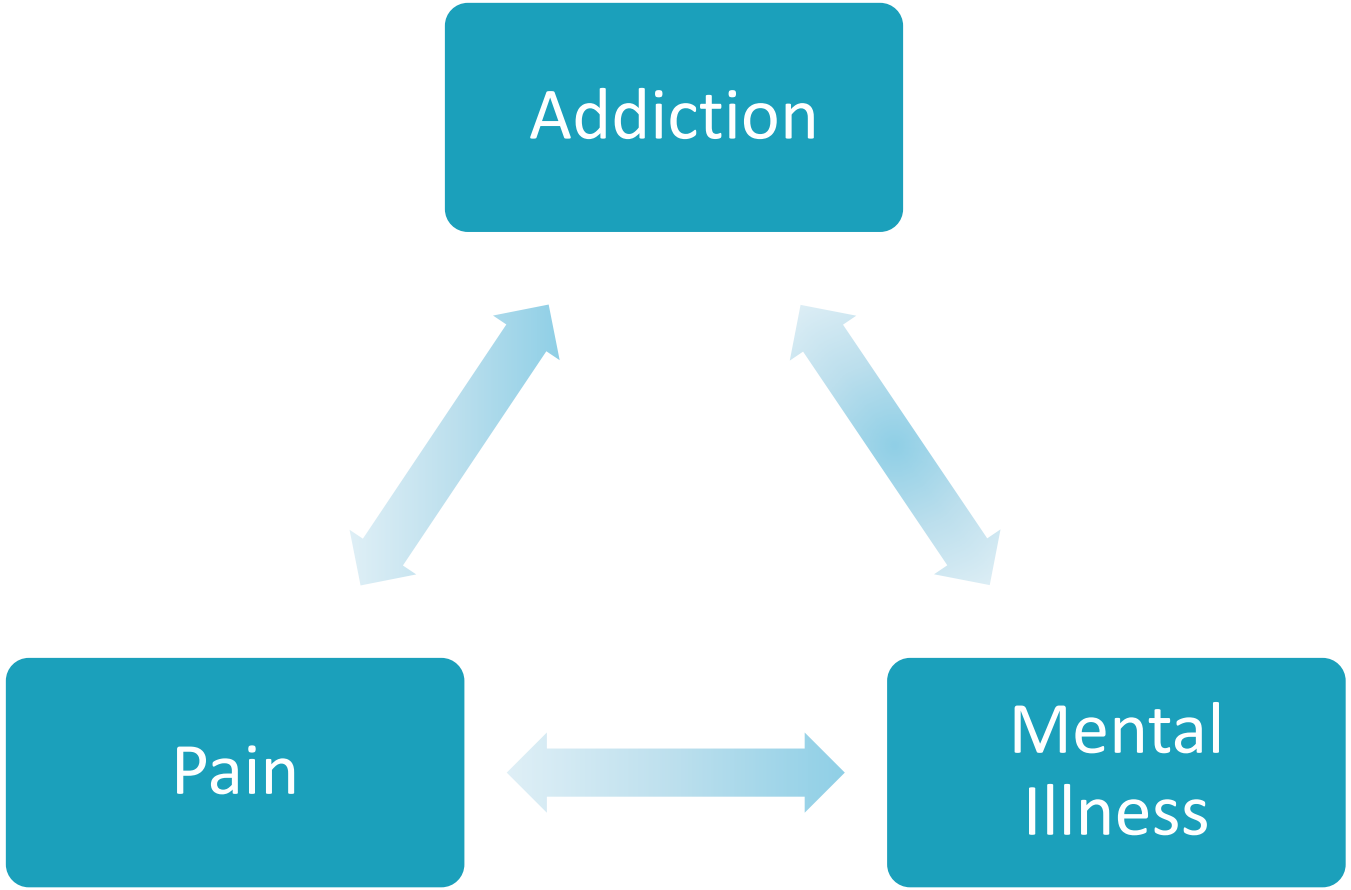
The Core Concept

Clinicians need to be able to navigate through the addiction-pain triangle, which is composed of three points:

- Addiction
- Pain
- Psychiatric Illness

The Pain-Addition Triangle

The Pain-Addition Triangle



An Intro to Addiction

The First Corner of the Triangle

Addiction Definition

- A primary, chronic disease of brain reward, motivation, memory and related circuitry.
- Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations.
- This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

An Intro to Addiction

The First Corner of the Triangle

Addiction Definition (continued)

- Addiction is characterized by:
  - Inability to consistently abstain from substance use.
  - Impairment in behavioral control.
  - Craving.
  - Diminished recognition of significant problems with one's behaviors and interpersonal relationships.
  - A dysfunctional emotional response.
- Like other chronic diseases, addiction often involves cycles of relapse and remission.
- Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

An Intro to Addiction

The First Corner of the Triangle

Addiction Definition (continued)

The 4 "C's"

Loss of Control

Compulsive use

Use despite Consequences

Cravings

What Drugs Can Cause Addiction?

- Only certain drugs are addictive and are able to stimulate the addiction circuitry.
  - Opiates/opioids
  - Cannabinoids (marijuana)
  - Psycho-stimulants (Adderall, cocaine)
  - Sedative/hypnotics (Benzodiazepines)
  - Nicotine
  - Alcohol
- Relatively very few chemical compounds can stimulate the addiction circuitry, in comparison to all pharmacologically active substances.

Opiates: More than Analgesia

- In the VULNERABLE population, opiates may induce:
  - A euphoric effect.
  - An immediate anti-depressant or anxiolytic effect (can be strongly reinforcing in the depressed or anxious patient).
- This can result in the patient developing a strong EMOTIONAL ATTACHMENT to the drug, which can occur in the absence of addiction.

Different Phenotypes of Drug "Dependence"

- Physiological dependence without evidence of addiction or positive psychological reinforcement.
- True drug addiction (SUD).
- Strong emotional attachment, without addiction.
- Presentation very similar to addiction.
- Strongly correlated with co-occurring psychiatric illness.
- Patients will not agree to tapering or discontinuation, but NOT due to addiction related psychological drives.

Is it Pain or Addiction?

The million-dollar question …

Behavior driven by addiction may be manifested by:

- Exaggerated pain scores which do not correlate to physical exam findings.
- Reported lack of benefit on high dosage regimen (ex. 10/10 pain while on 300mg of MS Contin)
- Patients becoming argumentative, angered, or threatening legal action if demands are not met.
- Patients making the provider feel incompetent or inadequate ("Whenever Ms. Smith comes in, I always feel uncomfortable, and she makes me feel bad.")

Mental Health

Be careful with that prescription pad …

- Do not jump to conclusions regarding diagnoses.
  - Patients with psychogenic pain syndromes can be very complex, with likely underlying unconscious conflicts and a history of traumatic experiences (emotional, sexual, physical).
- Avoid temptation to prescribe
  - Patients with addiction may ask for medications to help with emotional distress and may request specific medications by name (chemical coping).
    - While this is certainly within reason, do not prescribe simply based on a request.
    - The use of SSRI's and other antidepressants may be helpful but be confident in what you're treating.
- Take time to know the patient.

Psychiatric Illness with Chronic Pain

- Depression and other mood disorders
- PTSD
- Personality Disorders
- Somatic Symptom Disorders (ex. hypochondriasis and conversion disorder)
- Anxiety disorders
- “ADHD,” which contributes to controlled substance polypharmacy with stimulant Rx

What TO do in the Psychiatric Patient with Chronic Pain

- Vigorously screen for mental health difficulties, especially mood disorders and PTSD.
- Delicately identify past traumatic experiences, which may be contributing to the patient's presentation.
- Refer to psychotherapy, when necessary. Ideally to a therapist who has experience in working with chronic pain patients.
- Be CAUTIOUS with prescription medications, and do not contribute to a polypharmacy picture.

What NOT to do in the Psychiatric Patient with Chronic Pain

- **DO <u>NOT</u> PRESCRIBE BENZODIAZEPINES.**
  - Absolutely no evidence supports this practice.
- Avoid the use of psychostimulants, including Adderall and methylphenidate, in patients with a history of addiction, unless there is **<u>unequivocal</u>** evidence of ADHD.
- Do not always treat all emotional complaints with a prescription.
  - The patient may be emotionally uncomfortable but pharmaceutical intervention is not always the right intervention.

Let's Summarize

Putting it all together …

So What's Going On?

- Refractory pain syndrome that has not responded to conventional treatments.
- Patient reports functionally impaired and continues to request or demand opiate analgesics.
- Behavior is driven by:
  - Addiction alone.
  - Addiction + chronic pain.
  - Psychogenic pain syndrome (pain due to underlying emotional trauma).
  - Somatic Symptom Disorder.
  - Any combination of the above.

Prioritization of Clinical Concerns

- Addiction should be addressed first.
  - Very difficult to treat chronic pain or delineate a mental health concern with active drug addiction.
  - Addiction may be LIFE THREATENING.
- Pain Management
  - Pharmacotherapy – avoid opioids, is possible.
  - Psychosocial interventions
    - CBT
    - Biofeedback
    - Mindfulness therapies
- Mental Health
  - Pharmacotherapy – be very judicious.
  - De-prescribe when appropriate: taper off medications that are likely not offering any benefit and only add to polypharmacy
  - Psychotherapy

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Pharmacotherapy Considerations in Psychiatric Patients

- Avoid benzodiazepines, and other sedative/hypnotics.
  - Have not been shown to be beneficial in the chronic pain patient.
  - Dangerous synergy with opiates.
  - Tend to lead to functional decline.
- The use of stimulants is not recommended, unless an ADHD diagnosis has been objectively substantiated.
- Address issues of polypharmacy and discontinue what is likely not necessary.

Thank You

Please email me at ejouney@med.umich.edu with any questions.