Changing Approaches to Management of Pain, Opioid Pain Relievers and Addiction: Implications for Psychologists

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Overview

- Overlap between pain and Substance Use Disorders (SUDs)
- Challenges in treating pain in those with SUDs
- Prescription opioids in those with and without SUDs
- System level approaches to improving treatment for those with pain and SUDs
Research Interests

- Pain
- Substance Use Disorders (SUDs)
- Rx Opioid Misuse
Chronic pain

• “An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.” [International Association for the Study of Pain (IASP)].
• In national surveys, 25% of adults in the US report some form of persistent and/or significant pain (Ilgen et al., 2008; Krueger and Stone 2008; National Center for Health Statistics 2006).
• Chronic pain is associated with poorer quality of life and decreased productivity (Becker et al., 1997; Stewart, 2003).
• Chronic pain is associated with increased risk of suicide (Ilgen et al., 2010; Ilgen et al., 2008).
• Chronic pain is linked to a higher prevalence of numerous psychiatric conditions (Currie & Wang, 2004; Dersh et al., 2002; Means-Christensen et al., 2008; Von Korff et al., 2005).
Chronic pain and SUDs

- In community samples pain is associated with increased risk of SUDs – mainly alcohol use disorders (Von Korff et al., 2005).
- Rates of SUDs in those with pain (Morasco et al., 2011):
  - In primary care, 10% of those with chronic non-cancer pain have a current SUD
  - In specialty pain care, 10-30% of patients have a current SUD
- Rates of pain in SUD treatment settings:
  - Up to ~50% of patients in addictions treatment report pain:
    - Rates are somewhat higher in programs that treat opioid dependence (Trafton et al., 2004; Potter et al., 2008).
    - Those with pain typically report more severe patterns of substance misuse, psychopathology and functional limitations.
Why do pain and SUDs co-occur?

- Individuals with pain are ‘self-medicating’
  - Appealing to many patients
  - Some support from self-report data (Riley & King, 2009).
  - Poorer outcomes in those who use alcohol to manage pain (Brennan, Schutte & Moos, 2005).
- Third variables explain this association
- Substance use → injury → pain (Ilgen et al., 2010).
Why do pain and SUDs co-occur? – Rx opioids

- Physical dependence on prescription opioids ≠ SUD
- SUD diagnostic criteria still apply but with reconsideration of tolerance and withdrawal
Physiologic Criteria:

**Tolerance**, as defined by either of the following:

a) a need for markedly increased amounts of the substance to achieve intoxication or the desired effect, or

b) markedly diminished effect with continued use of the same amount of the substance

**Withdrawal**, as defined by either of the following:

a) the characteristic withdrawal syndrome for the substance, or

b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms
Physiologic Criteria:

Note:

*Tolerance and Withdrawal are not counted for those taking medications under medical supervision such as analgesics, antidepressants, anti-anxiety medications or beta-blockers.*
DSM-IV: Criteria for SUDs

- **Substance abuse**: significant impairment or distress as manifested by 1 or more of the following, occurring within a 12-month period:
  - Failure to fulfill major role obligations at work, school, or home
  - Use in situations in which it is physically hazardous
  - Recurrent substance-related legal problems
  - Continued use despite social or interpersonal problems

- **Substance dependence**: significant impairment or distress, as manifested by 3 or more of the following, occurring any time in the same 12-month period:
  - Tolerance: (a) need for increased amounts to achieve intoxication or the desired effect or (b) diminished effect with continued use of the same amount of the substance
  - Withdrawal: (a) The characteristic withdrawal syndrome for the substance or (b) substance is taken to relieve or avoid withdrawal symptoms
  - The substance is often taken in larger amounts or over a longer period than intended
  - There is a persistent desire or unsuccessful efforts to cut down use
  - Excess time is spent obtaining, using or recovering from use
  - Decrease of important social, occupational, or recreational activities
  - Continued use despite knowledge of problems due to use
Why do pain and SUDs co-occur? – Rx opioids

- Physical dependence on prescription opioids ≠ SUD
- SUD diagnostic criteria still apply but with reconsideration of tolerance and withdrawal
- Pseudoaddiction (Weissman & Haddox 1989).
- Opioid induced hyperalgesia (Angst & Clark 2006).
- The terminology surrounding opioid misuse is confusing
Defining “opioid misuse”

- Sometimes called “opioid abuse”, “extra-medical use” or “non-medical use” of opioids
- Other aberrant drug-related behaviors –
  - lost meds, early refill requests, borrowing/sharing meds, getting meds from other providers (Dr. shopping?)
- NSDUH - “Have you ever, even once, used NAME OF DRUG that was not prescribed for you or that you took only for the experience or feeling it caused?”
### Pain medication misuse

<table>
<thead>
<tr>
<th>Is the medication being used for pain relief? (vs. other effects)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Yes</td>
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</table>

<table>
<thead>
<tr>
<th>Is the medication taken as prescribed? (to you!)</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td>✔</td>
</tr>
</tbody>
</table>
Clinical implications of co-occurring pain and SUDs

- The presence of an SUD is associated with poorer functional outcomes following pain treatment
  - Those with an SUD were 70% less likely to report functional improvements during standard pain treatment than those without an SUD (Morasco et al., 2011).

- Chronic pain is associated with a poorer course of post-treatment outcomes following SUD treatment (Larson et al. 2007).
  - In a large addictions treatment program, patients with persistent pain were more likely to drop out of treatment and were less likely to be abstinent at 1-year (Caldeiro et al. 2008).

- Need to improve methods for identifying and treating co-occurring pain and SUDs.
Opioids for the treatment of chronic pain

- Opioids are now the most common form of treatment for chronic non-cancer pain (Turk & Okifuji, 2002).
- In all patients, there are concerns about:
  - Lack of data on the efficacy of long-term opioid therapy for non-cancer pain
  - Overdose
  - Misuse and diversion
Rates of prescription painkiller sales, deaths and SUD treatment admissions (1999-2010)
Is overdose risk related to dose of medication?

Effect of Dose on Risk of Unintentional Overdose Death, by Condition Type

- Hazard Ratio
- Daily Prescribed Dose, Morphine-Equivalent mg

Bohnert et al., 2011
Risk of Unintentional Overdose for SUDs

Bohnert et al., 2012
Past Year Substance Use Among U.S. Residents (Age 12 or older); 2010 NSDUH

- Marijuana: 11.5%
- Nonmedical Use of Prescription Pain Relievers: 4.8%
- Nonmedical Use of Prescription Tranquilizers: 2.2%
- Cocaine: 1.8%
- Nonmedical Use of Prescription Stimulants: 1.1%
- Ecstasy: 1.0%
- Inhalants: 0.8%
- Nonmedical Use of Prescription Sedatives: 0.4%
- LSD: 0.3%
- Heroin: 0.2%
Ways to assess for pain medication misuse

- Past 30 day pain medication misuse
  - Current Opioid Medication Misuse (COMM; Butler et al., 2007)
    - “How often have you needed to take pain medications belonging to someone else?”
    - “How often have you had to go to someone other than your prescribing physician to get sufficient pain relief from your medications?”
    - How often have you taken your medications differently from how they are prescribed?
    - “How often have you had to take more of your medication than prescribed?”
    - “How often have you borrowed pain medication from someone else?”
    - “How often have you used your pain medication for symptoms other than for pain?”
Results of screening surveys of patients in different settings

- Adults treated in a low-income dental clinic at the University of Michigan (N = 384)
  - 38.6% reported pain medication misuse
- Adults treated (n = 477) in an Urban Emergency Department
  - 39.8% reported pain medication misuse
- Adults in residential SUD treatment (N = 351)
  - 68% endorsed pain medication misuse
Prevalence of prescription opioid misuse in SUD treatment

Price et al., in press.
Opioid prescribing guidelines for those with SUDs

- VA opioid prescribing guidelines

- Those with a current SUD should
  - Receive concurrent SUD treatment
  - Frequent monitoring
Opioid treatment in the VHA

- Poor overall adherence to clinical guidelines
  - VHA primary care (Krebs et al., 2010):
    - 14% assessed for drug/alcohol use
    - 11% used an opioid agreement
    - 15% used urine drug screens
  - SUD vs. non-SUD patients (Morasco, Duckart & Dobscha, 2011):
    - 30% had a mental health appointment (versus 17% of those without an SUD)
    - 35% had a SUD treatment appointment
    - 47% received a urine drug screen (versus 18% of those without an SUD)
  - High dose prescribing ($\geq 180$ mg/day morphine equivalent dose; Morasco et al., 2010):
    - 2.4% of all chronic pain patients; 8.2% of those w/ an opioid
    - More likely to have 4+ pain conditions, MH and SUDs and prescription of a benzodiazepine
Improving care for VHA patients with chronic pain and SUDs

- Increase the awareness of and adherence to clinical practice guidelines:
  - Use of urine drug screens
  - Referrals to specialty SUD treatment
- Identification and re-evaluation of high risk patients based on:
  - Current opioid dose
  - Adverse event
  - Problematic pattern of service utilization
Improving care for VHA patients with chronic pain and SUDs

- In all settings, improve measurement of:
  - Pain
  - Functioning
  - Opioid misuse
  - Substance use disorders

- Increase awareness of effectiveness of behavioral treatments for pain and availability of these treatments

- Increase use of evidence-based SUD treatment
  - Pharmacotherapy for those with opioid dependence
    - Weiss et al., 2011 – maintenance (47%) far better than taper (8%)
(i) Pharmacotherapy with approved, appropriately-regulated opioid agonists (e.g., buprenorphine or methadone) must be available to all patients diagnosed with opioid dependence for whom it is indicated and for whom there are no medical contraindications… in addition to, and directly linked with, psychosocial treatment and support.

- If agonist treatment is contraindicated or not acceptable, antagonist medication (e.g., naltrexone) needs to be available and considered for use when needed.
Opioid agonist treatment can be delivered in either or both of the following settings:

- **Opioid Treatment Program (OTP).**
  - formally-approved and regulated opioid substitution clinic using methadone or buprenorphine
  - 32 OTPs in house plus 22 by off-site contract.

- **Office-based Buprenorphine Treatment.**
  - only by a “waivered” physician
  - includes non-specialty settings (e.g., primary care)
  - 123 medical centers and 121 community clinics
## Change in opioid agonist pharmacotherapy FY09-11

<table>
<thead>
<tr>
<th>Year</th>
<th>Opioid Diagnosis</th>
<th>Treated* (num)</th>
<th>Diagnosed (denom)</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY09</td>
<td>Dependence</td>
<td>10681</td>
<td>34736</td>
<td>30.1%</td>
</tr>
<tr>
<td>FY10</td>
<td>Dependence</td>
<td>12149</td>
<td>38484</td>
<td>31.6%</td>
</tr>
<tr>
<td>FY11</td>
<td>Dependence</td>
<td>12894</td>
<td>40753</td>
<td>31.6%</td>
</tr>
<tr>
<td>Change FY09-11</td>
<td></td>
<td>+20.7%</td>
<td>+17.3%</td>
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</tbody>
</table>

Includes office based care (buprenorphine/naloxone) Opioid Treatment Program (methadone or buprenorphine/naloxone), or fee basis care
New VHA initiatives to improve care for those with pain (and SUDs)

- CBT for the management of chronic pain (evidence-based psychotherapy role-out)
- Shift from opioid pain care agreements (‘opiod contracts’) →
  - Signed Consent for Long-Term Opioid Therapy for Chronic Pain
  - Patient Information Guide called “Taking Opioids Responsibly”
- Directive in concurrence
Resources

- National Pain Management Website (www.va.gov/painmanagement)
- VA/DoD Clinical Practice Guideline on Management of Opioid Therapy (OT) for Chronic Pain (2010)
  - http://www.healthquality.va.gov/Chronic_Opioid_Therapy_COT.asp
- Handbook 1004.01 Informed Consent for Clinical Treatments and Procedures
- Monthly “Spotlight on Pain Management” webinar (collaboration with HSR&D Center for Information Dissemination and Educational Resources)
- 56 pain-related Office of Research and Development funded research projects in FY11
- SUD Quality Enhancement Research Initiative (QUERI) SUD-Pain Work Group; see pages 54-57 in Strategic Plan available at http://www.queri.research.va.gov/about/strategic_plans/sud.pdf
Thank You!

Please feel free to contact me:

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