Planning Access to Treatment for Patients with Addiction and Pain

Speaker Information

Presented by Gayle M Taylor-Ford, LSCSW, LCAC

Executive Director, Therapy Services LLC

www.therapyservicesonline.com

International Pain Foundation Board Member, Secretary

www.internationalpain.org

Government Relations Advisory Committee Member, National MS Society

www.nationalMSsociety.org

Session Goals

- List genetic and environmental factors contributing to the influence, development and course of CNCP (chronic non-cancer pain).
- Clinicians will understand CNCP, addiction, and other behavioral issues to apply services for chronic pain patients with or in recovery from SUD (substance use disorder).
- Describe the complexities of CNCP and SUD's.
- Patients with these co-occurring chronic conditions can be treated effectively.

Session Goal 1

List genetic and environmental factors contributing to the influence, development and course of CNCP (chronic non-cancer pain).

CNCP (Chronic Non-cancer Pain)

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." It may or may not be associated with a pathologic process and can occur in the context of numerous diseases and syndromes. It can be complicated by psychological comorbidities and a range of contributing factors and can have a range of effects on daily functioning. (Management of CNCP, June 2012).

Prevalence of Chronic Pain in the U.S.

Per the U.S. Department of Health and Human Services Centers for Disease Control and Prevention

Approximately 20.4% of US adults had chronic pain and 8% had high-impact chronic pain – meaning pain that limited at least one major life activity – in 2016.

Both were more prevalent among adults living in poverty, adults with less than a high school education, and adults with public health insurance. (Dahlhamer, Lucas, Zelaya, 2018)

exhibit 1-1 statistics on substance Use and chronic pain in the United states (SAMHSA, TIP Series 54)

Chronic pain patients who may have addictive disorders	32%
People ages 20 and older who report pain that lasted more than 3 months	56%
People experiencing disabling pain in the previous year	36%
People ages 65 and older who experience pain that has lasted more than 12 months	57%
Civilian, noninstitutionalized U.S. residents ages 12 and older who report nonmedical use of pain relievers in past year	5%
People ages 12 and older who report that they initiated illegal drug use with pain relievers	19%
People with opioid addiction who report chronic pain	29-60%

Table 1 Factors Associated with the Development of Chronic Pain

	Factor
Demographic	Age, Gender, Ethnicity and cultural background, Socio-economic background, Employment status and occupational factors.
Lifestyle and Behavior	Smoking, Alcohol, Physical Activity, Nutrition, Sunshine and Vitamin D.
Clinical	Pain, Multimorbidity and mortality, Mental Health, Surgical and medical interventions, Weight, Sleep disorders , Genetics.
Other	Attitudes and beliefs about pain History of violent injury, abuse, or interpersonal violence.

(Mills, Nicolson, & Smith 2019)

Genetics

- Chronic Pain is a heritable phenotype, and the presence of chronic pain clusters in family groups through genetic and 'maternal' effects.
- Chronic Pain is also the result of genetic contributions to underlying diseases that include chronic pain (i.e. Diabetes, MS, etc.).
- There are known to be at least 150 genes associated with chronic pain and that number is expanding. (i.e. immune, inflammatory, and stress related pathways, etc.).

Genetic Findings

Research has generally failed to identify any single genetic variant that contributes substantially to the population risk of developing chronic pain; **there is no 'chronic pain gene'.**

It is more likely that a combination of genetic variants increases the risk of developing chronic pain.

Studies are ongoing….

Session Goal 2

Clinicians will understand CNCP, addiction, and other behavioral issues to apply services for chronic pain patients with or in recovery from SUD (substance use disorder).

Addiction

Per the American Psychiatric Association

Addiction is a complex condition, a brain disease that is manifested by compulsive substance use despite harmful consequences.

DSM-5 Classifications

Substance-related disorders are sorted into 10 separated classes of drugs in the DSM-5.

Alcohol; Caffeine; Cannabis; Hallucinogens; Inhalants; Opioids; Sedatives, hypnotics and anxiolytics; Stimulants; Tobacco; Other (or unknown) substances.

These 10 classes are not fully distinct. All drugs taken in excess produce such an intense activation of the brain reward system that normal activities may be neglected. Instead of achieving reward system activation through adaptive behaviors, drugs of abuse directly activate the reward pathways.

Mild, moderate, or severe?

The diagnostic criteria for substance-use disorders is broken down into three categories to include: Mild SUD, Moderate SUD, and Severe SUD.

These distinctions can be distinguished by a licensed substance abuse counselor by utilizing the DSM-5 criteria and/or using a tool such as the DSM-5 Diagnostic Criteria for Substance-Use Disorder Checklist designed for use by the SASSI Institute.

Other Behavioral Disorders: Anxiety

Anxiety is common in patients with CNCP and current or recovering SUD. The presence of an anxiety disorder has a negative effect on treatment of CNCP. Anxiety contributes to patient suffering and can make patients less able to participate in their pain management. Treating anxiety lowers pain scores, reduces the need for analgesics, and improves quality of life. (SAMHSA, TIP Series 54).

Other Behavioral Disorders: Depression

Patients who have CNCP and comorbid depression tend to:

- Have high pain scores.
- Feel less in control of their lives.
- Use passive–avoidant coping strategies.
- Adhere less to treatment plans than patients who are not depressed.
- Have greater interference from pain, including more pain behaviors observed by others.
- Respond less well to pain treatment, unless depression is addressed.

(SAMHSA, TIP Series 54).

Depression Continued

It may be difficult to determine whether a patient's negative affect represents clinical depression or the psychological distress of chronic pain, SUD, or other medical conditions. Sleep apnea, hypothyroidism, and hypogonadism (which can result from prolonged exposure to opioids) can present as depression. It is important to know that **clinical depression worsens other medical illness'** including chronic pain and can interfere with ongoing treatment management. (SAMHSA TIP Series 54).

Other Behavioral Disorders: PTSD

CNCP and PTSD frequently co-occur, and their symptoms often overlap. Both conditions are characterized by hypervigilance, attentional bias, stress response, and pain amplification as well as anxiety, hyperarousal, avoidance behavior, emotional lability, and elevated somatic focus. (SAMHSA, TIP Series 54).

Somatization

Somatization refers to inordinate preoccupation with and communication about physical symptoms. Although a diagnosis of somatization disorder is rare in patients who have chronic pain, multiple pain complaints are almost always present in somatization disorder.

(SAMHSA, TIP Series 54)

Other Behavioral Disorders: Suicide

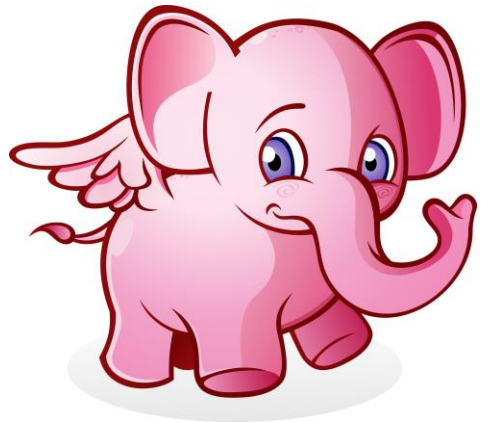
Including suicidal ideation and suicide attempts, it was found that the risk for suicide “appeared to be at least doubled” in patients who experienced CNPC. (SAMHSA, TIP Series 54).

Suicide is a leading cause of death among people who misuse alcohol and drugs. Approximately 22 percent of deaths by suicide involved alcohol intoxication, with a blood-alcohol content at or above the legal limit (CDC, 2014b). Opiates (including heroin and prescription painkillers) were present in 20 percent of suicide deaths, marijuana in 10.2 percent, cocaine in 4.6 percent, and amphetamines in 3.4 percent (CDC, 2014b).

Session Goal 2

Describe the complexities of CNCP and SUD's.

Complexities



OPIOIDS

How do Opioids work? What do Opioids do?

Do Opioids cause an increase in CNCP?

Does CNCP lead to substance use disorder?

Must a patient have a substance use disorder is they experience cravings?

Can someone with an addiction be treated for chronic pain?

Can a Chronic Pain patient be treated for a substance use disorder?

How do Opioids work?

When looking at the ten classifications of substances in the DSM-5, whether we are talking about drugs of abuse or Opioids prescribed by a physician and taken as prescribed, they do the same thing…. **Alter brain chemistry**.

To specifically look at Opioids, if you have knee pain and take an Opioid, the drug does not travel to the knee and fix the pain, it travels to the Opioid receptors in the brain.

What do Opioids do?

If an Opioid is administered by a nurse, a doctor, or on the street, the Opioid must cross the blood brain barrier and enter the Central Nervous System. In the CNS, the Opioid binds to Opioid receptors found on the pain signaling neurons. This causes molecular and cellular changes that prevent these neurons from sending signals to each other. Which causes the sensation of pain to stop.

Do Opioids cause an increase in CNCP?

When Opioid pills are used for 4 or more weeks, it makes the patient more sensitive to pain and that makes the pain feel worse.

“Opioids do provide relief by blocking pain. However, the body reacts by increasing the number of receptors to try to get the pain signal through again. So when the drug wears off, a person will experience more pain for about three days. If they continue to take opioids, the pills become less and less effective. The pain keeps increasing not because of an injury, but due to the opioids themselves.

In addition, our bodies have natural opioids called endorphins. If your body becomes used to opioid pain medication, its ability to create and use natural endorphins will decrease. This makes you lose the ability to reduce pain on your own.”

(Clavel, Jr., MD, Alfred , 2019).

Does CNCP lead to substance use disorder?

This depends on how the pain is treated as well as many other factors. Pain itself does not lead to SUD. How the pain is treated can, even for someone who does not have a genetic predisposition for SUD.

Opioid treatment for pain works. However, the body can quickly develop tolerance which leads to taking larger doses of the medication. Taking larger doses also leads to more heavily relying on the medications to feel better. Increasing the dosage and timing of this medication can be dangerous and can lead to misuse, whether intentional or not. (American Addiction Center 2019)

This does not mean every person prescribed an opioid medication is addicted to that medication or has a substance use disorder. It does mean they need to take extra care and caution as they are at a higher risk of developing a SUD.

Must a patient have a substance use disorder if they experience cravings?

"The results show that patients taking opioids who are not dependent or addicted, according to accepted measurements, **do experience drug cravings**. Further, levels of craving were weakly associated with current levels of pain or average pain over 24 hours. The authors concluded that craving is a mental experience distinct from pain itself. Also, the results show that craving is a common experience with opioid therapy and may or may not be related to substance abuse disorders and higher risks for drug misuse." (Research Review 2019).

Can someone with an addiction be treated for chronic pain?

Primary Care Physicians (PCP) are responsible for providing pain care to more than half of all chronic pain patients. Physicians who treat pain patients face ethical and legal issues when or if their patients develop addiction. Therefore, there are clinicians who won't treat patients with chronic pain at all– and label any small error or misjudgment as drug-seeking behavior and fire them from their practice or refuse to prescribe opioid medications. (Ault 2019)

There are physicians who take the time to listen to each individual story, seek advice from peers, and use knowledge, compassion, and skill to provide the patient with the best care possible given their specific situation.

Yes, someone with an addiction can be treated for chronic pain, but they may need to accept a referral for more specialized care than with their PCP.

Can a Chronic Pain patient be treated for a substance use disorder?

A chronic pain patient who is taking opioids for pain management but needs treatment for a substance use disorder such as alcohol or cocaine in an inpatient or outpatient setting is going to have a very difficult time finding a treatment facility that will treat them while they are on the opioid medication. Addictions treatment facilities are abstinence based and expect the clients to be free from all mood- and mind-altering substances, including opioids.

When I contacted other addiction treatment providers in my state of Kansas, I received this response; “They would either change the medication immediately or do a taper then switch. Depending on the dosage.”

You cannot be in substance abuse treatment and be taking opioid medications.

What is a Pain Management Agreement?

A pain management agreement is a contract between the physician and the patient to ensure the patients who are prescribed opioid medications take them as prescribed. The purpose is to protect the physician if the patient abuses the medication and to protect the patient from drug abuse.

If you are asked to sign a pain management agreement it is essential that you understand what you are signing.

What is included in a pain management agreement?

1. You agree to take the medication exactly as prescribed.
2. You agree to random drug testing.
3. You agree to only use one pharmacy to fill all your prescriptions.
4. You agree that lost, stolen, or destroyed medication will not be replaced.
5. You agree to not request nor take pain medications from other providers.

(Gordon 2019)

Session Goal 4
Planning Access to Treatment for Patients with Addiction and Pain

Type of Care to Access

- SUD treatment to overcome an opioid use disorder.
- SUD treatment to overcome a substance use disorder but you have chronic pain and are prescribed opioids that are taken as directed.
- CNCP treatment and you have an active SUD.
- CNCP treatment and you are in recovery from SUD.

MAT versus Traditional Treatment for Opioid Addiction

Medication-Assisted Treatment (MAT) is the use of medications along with counseling and behavioral therapies to treat SUD's. For people struggling with opioid addiction a combination of therapies and MAT can help to sustain recovery.

The medications used for MAT from opioid addiction are approved by the FDA. However, combining medications used in MAT with anxiety treatment medications which are Benzodiazepines such as Xanax or Valium can be fatal. (SAMHSA 2019)

Medications used in MAT

Methadone (Dolophine, Methadose), Buprenorphine (Suboxone, Zubsolv), and Naltrexone (ReVia, Vivitrol), are used to treat opioid addiction to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. People may safely take medications used in MAT for months, years, several years, or even a lifetime. Plans to stopping a medication must always be discussed with a doctor. (SAMHSA 2019).

Barriers to MAT

- A misguided belief that MATs just replace one addiction for another.
- Insufficient number of trained prescribers, leading to improper dosing and treatment failure.
- The history that many treatment programs are abstinence based and do not know enough about MAT to be accepting of it.
- Insurance and/or Medicaid programs that have restrictions and limits that limit access to MATs. The limits can include dosages prescribed, annual or lifetime medication limits, authorization requirements, and the “fail first (step therapy)” criteria requiring that other therapies be attempted first. (American Nurses Association 2019)

SUD Treatment when you are prescribed an Opiate

You likely will not be able to access treatment in an inpatient setting unless you can find it in a hospital setting. Even in a hospital setting they will need to find it “medically necessary” to be in a hospital.

In an outpatient setting you may need to find someone who is willing to work with the patient on an individual basis.

There likely will not be group treatment for someone taking Opioid medication to sit next to someone trying to overcome an Opioid medication addiction in that group. Not a good mix.

CNCP Treatment

Whether you have an active addiction or are in recovery from an addiction you need to be up front and honest with your physician.

Then the physician can make an informed decision to decide if you are in the right place for treatment or if you should be referred to a different type of provider. If you start with your PCP you may be referred to a Pain Clinic for example.

How do we plan access to treatment for someone with addiction and pain?

1. When the CNCP is atypical, or when there is comorbid psychiatric illness or SUD history, specialty consultation may be indicated.
2. Optimal treatment for CNCP may require more specialized care such as in a Pain Clinic.
3. When treatment teams try to accommodate individuals with coexisting problems such as addiction and pain, the quality of care improves for all patients.
4. Providers must be prepared to act as advocates for their patients when services and supports that are normally readily available and effective prove inaccessible for the patient.

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Questions?

Contact Information

GAYLE M TAYLOR-FORD, LSCSW, LCAC

15147 Beverly Street

Overland Park, Kansas 66223

GAYLE@THERAPYSERVICESONLINE.COM

785-221-7560