Pain Management and Opioid Treatment Services

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40th Annual Governor's Conference on Substance Abuse

A. Three Critical Factors to Help Guide Management of Chronic Pain

(Troy Parks FEB 24, 2017, Staff Writer, AMA Wire @Troy_AMAWire)
Chronic pain is "common and complicated,":

- In the United States, one in three people suffer from chronic pain and one in 12 struggle to cope with moderate to severe pain.
- Complaints of pain account for up to 20 percent of outpatient visits with a cost of more than $600 billion in health care expenses, lost income, decreased productivity and several other expenses every year.

Three critical factors to understanding patients with chronic pain and the treatment options available.
1. Variables that affect the individual chronic pain experience. In some cases, especially involving neural injury, pathologic and maladaptive responses within somatosensory pain-signaling pathways develop and persist after the acute injury has healed, creating ongoing pain signals. Some patients are predisposed to increased sensitization of pain pathways as a result of genetic and epigenetic factors.

2. Stressors that affect patients. Patients often struggle with stressors in their personal lives at work or home that can worsen chronic pain. Socially and culturally determined constructs of pain, suffering and disability also influence an individual's response to pain, and the presence of co-morbid mental health disorders can exacerbate pain and further complicate treatment.

3. Differing treatments for patients with pain. Unfortunately, treatments designed for acute, self-limited pain are usually inadequate and may be inappropriate for chronic pain. The treatment of chronic pain often requires a multidimensional approach. Ultimately, the goals in these patients are to reduce pain, restore function, improve quality of life and cultivate well-being. Many treatment strategies are available, including psycho-behavioral approaches, procedural or interventional techniques, physical and other manual therapies, and medications.

B. Therapeutic Approaches to Pain Management

Lapham, Sandra: "Alternatives to Opioids for Chronic Pain Relief" National Drug Court Institute, Drug Court Practitioner Fact Sheet, June 2016 Vol XI, No.2
1. Cognitive Behavioral Therapy – a person's response to psychosocial stressors and thoughts and beliefs about pain can affect pain syndromes.

2. Physical Therapy – People with chronic pain worry that movement and exercise will cause pain to worsen, but generally the opposite is true.

3. Yoga – Some randomized clinical trials support the use of yoga for persistent pain.

4. Acupuncture – Considered a complementary and alternative treatment. Acupuncture can be effective with other forms of treatment and by itself.

5. Spinal Manipulation Therapy (SMT) – Adjusts the spine and move the vertebrae into alignment using direct force. In controlled studies SMT has produced small-to-moderate clinical benefits.

6. Massage Therapy – Therapeutic massage is a useful option that helps some people and may be an important part of a treatment package.

C. **Self Management of Pain**

Lapham, Sandra: "Alternatives to Opioids for Chronic Pain Relief" National Drug Court Institute, Drug Court Practitioner Fact Sheet, June 2016 Vol XI, No.2

Goals:

1. Reduce Pain Directly
   - Heat/cold applications – hot baths/showers, heating pad; cold packs, hot/cold skin patches
   - Medications – Over-the-counter: aspirin, ibuprofen, naproxen (Advil, Motrin, Aleve) are non-steroidal anti-inflammatory; prescription medication.

2. Maintain functioning and reduce risk of recurrence – relief of associated mood disorders and sleep disturbances; return to valued social, vocational and recreational activities; improve physical fitness
   - Exercise
   - Weight loss

3. Cope with pain – learning to coexist with pain rather than curing it.
   - Distraction – drawing away attention from pain to other matters e.g., talking to friends, video games, listening to music
   - Guided imagery – focusing on healing images that elicit healing feelings in 10-20 minutes
   - Progressive relaxation
   - Meditation

4. Address other concerns that contribute to pain
   - Anxiety, depression
   - Chronic fatigue
   - Addiction
   - Work-related problems
   - "Fun deprivation" – chronic pain prompts a retreat from daily life; find things that give pleasure

D. **Managing Addiction Risk with Patients Treated with Opioids**

(CSAT "Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders" Treatment Improvement Protocol (TIP) Series 54.)

1. Help patients adhere to treatment plans by:
   - Employing treatment agreements
   - Regulating visit intervals
   - Controlling medication supply – write prescriptions for shorter periods of time
   - Conducting urine drug testing (UDT)
   - Including the patient's support network in monitoring efforts

2. Nonadherence – includes, among many behaviors:
   - Being more interested in opioids than other medications or any other aspect of treatment
   - Taking doses larger than those prescribed or increasing doses without consulting physician
   - Insisting higher doses are needed
   - Resisting UDT, referrals to specialists, and other aspects of treatment
   - Resisting changes to opioid therapy

3. Nonadherence for reasons other than addiction
   - Misunderstanding instructions
   - Seeking euphoria
   - Using medications to deal with fear, anger, stress, sleep problems and other issues
   - Diverting medication for profit
   - Coping with untreated mental disorders
   - Coping with undertreated pain, also known as pseudoaddiction
   - General

E. **Opioid Treatment Services** *(The ASAM Criteria* 2013*,* pp 290-298)

- Opioid Treatment Programs (OTP) - Medication by clinic (no prescriptions)
- Office-based Opioid Treatment (OBOT) - Medication by prescription, filled elsewhere
- Agonist medication (methadone and buprenorphine)
- Antagonist medication (naltrexone)

Similar to Level 1 services in intensity, can be combined with other services

F. **CDC Guidelines (2016) and DoD/VA Guidelines (2017)**

March 7, 2017
Editor-in-Chief: William Haning, MD, DFASAM, DFAPA
http://www.asam.org/quality-practice/asam-weekly/archives

ASAM Weekly has previously included a link to and brief discussion of the Centers For Disease Control (CDC) *Guideline for Prescribing Opioids for Chronic Pain* from 2016. 52 pages long, it included a short summary of recommendations that was a model of concision, 12 points that emphasized restraint and careful monitoring.

Just-released Department of Defense – *Veterans Administration Clinical Practice Guideline for Opioid Therapy for Chronic Pain*; it is 198 pages, of which much is reference material and careful documentation of the process by which the recommendations were developed. Particularly valuable are four modules, algorithms that describe the management approach to four separate clinical problems:

- General appropriateness for opioid therapy
- Treatment with opioid therapy
- Tapering or discontinuation of opioid therapy
- Management of patients currently on opioid therapy.

In a side-by-side comparison with the CDC guidelines, four notes warrant presentation:

1. Both documents provide explicit, quantitative, recommended limits to daily opioid dosage.

2. Neither document proposes that there is no place for long-term opioid therapy, in some patients. Said differently, both documents allow for the possibility that there is a population of patients for whom some long-term opioid therapy is appropriate; however there is a clear and insistent de-emphasis of the place for long-term opioid therapy, throughout both documents.

3. The two documents are mutually concordant indicating interagency cooperation.

4. In making recommended upper limits to opioid prescribing dosage, neither document proposes that the actual opioid dose is indicative of an opioid use disorder. This is consistent with the philosophic trend that has been employed in developing criteria for all substance use disorders from DSM-III forward. That is, the frequency or the amount of the substance used is not the issue in determining a usage disorder (dependence); the consequences of the usage are the issue in determining a disorder.

CDC recommendations for prescribing opioids for chronic pain outside of active cancer, palliative, and end-of-life care

(a) Determining When to Initiate or Continue Opioids for Chronic Pain

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

(b) Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

(c) Assessing Risk and Addressing Harms of Opioid Use

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

* All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); see full guideline for evidence ratings.

LITERATURE REFERENCES AND RESOURCES

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For more information on the new edition: www.ASAMcriteria.org

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