Managing Patients with Pain, Psychiatric Co-Morbidity & Addiction

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DR. JOHN RENNER: Good morning. By way of disclosure, I just want to mention that I have some stock in Johnson & Johnson. This is the material that we’re going to cover with the talk today.
We’ll begin by discussing the prevalence of co-occurring psychiatric disorders and addiction in chronic pain patients; then talk a little bit about how you treat co-occurring psychiatric disorders; then shift to diagnosing addiction and substance abuse in chronic pain patients; and finally, treating co-occurring addiction in chronic pain.

Start with prevalence.
This slide captures some of the more common psychiatric disorders and gives you some indication of how common this is in chronic pain patients. You’ll see with depression, significantly more depression than in the general population, similarly in anxiety disorders, personality disorders, PTSD the range can be from 20% to 34%. There you have to look at the populations that you’re comparing this to. Only 1% of the general population has PTSD, but if you work at the VA where I am, 20% of combat vets are going to have PTSD, and civilians with trauma the range is 3% to 15%, so it can be a common problem.

Substance use disorders, it ranges to about 10% in the general population but almost three times as high in individuals with chronic pain problems. Somatoform disorders, we really don’t have good data for the incidents in the general population, but in chronic low back pain patients and in-patient rehab, it goes as high as 97%, so there’s really an undetermined range with somatoform disorders.
This slide captures some of the data on pain and depression. Among patients with major depressive disorder, significantly higher proportion reported chronic pain than those without that. They're at 66% versus 43%. Disabling chronic pain was present in 41% of those with major depression versus only 10% of those without major depression, so again, you can see the higher risk in the chronic pain patients.
The other point that I want to make is that there’s a very high co-morbidity between depression and anxiety disorders. People with chronic pain, major depression, have poor quality of life, increased somatic symptoms, higher prevalence of panic disorder, and more than six-fold greater prevalence of anxiety disorders, so very high co-occurring incidents of depression and anxiety disorders.

The depression may be more obvious to you, but if you get any sense that your patient is depressed, you need to screen them for that and then you need to also ask questions about anxiety disorders. They are going to be very common in the same patients.
I think if you have any suspicion at all, particularly about depression in chronic pain patients, I think it’s really important as part of your standard management that you screen them for depression and anxiety disorders and substance use disorders.
How do you treat co-occurring psychiatric disorders in chronic pain patients?
First of all is that you really want to optimize self-management of the pain and depression. This looks at one trial where they optimized antidepressant therapy by combining it with the pain self-management program. That produced significant reduction in the depression severity, moderate reduction in the pain severity; so interestingly enough, you’re probably going to see better response to depression than you are necessarily to see improvement with the pain. If you do see improvement with depression, you’ll probably see it relatively early within the first or second months of treatment.
The second point I would want to make is that for treating both the depression and co-occurring anxiety, you’re most common pharmacotherapy is probably going to be the SSRIs. Though this slide compares a variety of antidepressants, you’ll see that the efficacy across this range of antidepressants is fairly comparable. They’re all effective. Nefazodone, or Serzone, probably works best in terms of improving sleep. It works best in terms of reducing anxiety. Paroxetine is the only other SSRI that has a very specific benefit for anxiety. One of the problems with nefazodone is panic damage. There is a black box warning with this drug, but in patients who can tolerate it; it may be a very effective drug to use.

As you can see with all of these drugs, there are problems with sexual dysfunction, problems with weight gain, except for bupropion and nefazodone, so there are side effects that you need to be concerned with all of these medications, but I’d look particularly at using paroxetine and nefazodone as medications that maybe helpful with patients with co-occurring pain, depression, and anxiety.
Pick standard antidepressant meds that you’re comfortable with. Make sure you’re using adequate doses and patients need to be on them for at least a month if you’re going to see an adequate response. You always, whenever possible, want to combine antidepressant therapy with cognitive behavior therapy. There’s no question that the treatment outcome is improved if you combine cognitive behavior therapy, plus the antidepressant. In some cases, you may want to use benzodiazepines, but here because of the risk benefit you want to start with low doses, go carefully. Monitor their prescriptions more carefully, and just be aware that there may be a higher risk for abuse.
If you look at the questions about when should you consider benzodiazepines, there is efficacy for treating general anxiety disorder, panic disorder, and agoraphobia. There’s probable efficacy for social phobia. Alcohol-induced anxiety disorders and there’s really little added risk for medication abuse or increased relapse, except in individuals who are primary sedative-hypnotic addicts.

If you’ve got any individual with a clear cut history of prior benzo abuse, those are the people you really have to be extremely careful about and avoid use; otherwise, the increased abuse of benzos is not very different in psychiatric patients or in addicted patients. It is slightly higher in those two groups than in the general population, but not dramatically so. I think there’s some over exaggerated concern about using benzodiazepines. By and large, they should never be your first choice with pain patients, and they should only be considered if patients have failed to respond to less abuse able medications.
This slide just lists the variety of psychiatric conditions and the most common medications that we would recommend for their use. There certainly are other options but these are the most common: For depression, start with the SSRIs. If they don’t work, I would consider nefazodone; with generalized anxiety disorder, buspirone in higher doses than is normally prescribed and SSRIs; panic disorder, again, SSRIs and nefazodone; social anxiety, paroxetine; for PTSD, paroxetine and citalopram. Prazosin is very effective for PTSD-induced nightmares*; and for bipolar disorder, my first choice would be valproate.

*Off-label use.
Slide 13: Managing Patients with Pain, Psychiatric Co-Morbidity & Addiction

Treatment Recommendations
Psychiatric Treatment in Patients with Chronic Pain

- Counseling
  - Cognitive Behavioral Therapy (CBT)
  - Motivational Enhancement Therapy (MET)
  - Twelve Step Facilitation (TSF)
  - Cognitive Processing Therapy (CPT)

- Self health groups (i.e., AA, NA)

I would also, again, emphasize the importance of adding cognitive behavior therapy. Cognitive processing therapy is a new approach that we’re using for PTSD and that’s of particular benefit in that subset of patients. Also, if you have any concerns about potential abuse or people with prior addiction histories, I would make sure they’re still connected with AA or NA.
Let’s move more specifically to diagnosing addiction and substance abuse in chronic pain patients.
First of all, you need to be aware of what your risks are. First of all, any active opioid dependence is obviously a situation where you’re going to get concerned, but that doesn’t mean that you’re really going to deny treatment to people. You just need to be much more cautious. If someone has a history of opioid dependence though they’re not currently in trouble, that just puts them at higher risk. Risk of any other classes of drugs puts them at risk.

Inadequately treated pain syndromes; this I think is something that physicians often don’t consider and sometimes while they’re well intended, they are overly conservative in treating pain in individuals with addiction histories. I think the reality is that by under treating pain in these patients, you’re actually more likely to precipitate new drug abuse. I think that you need to really be sure that despite their history they get adequate treatment for current and existing pain problems. Any other psychiatric co-morbidity will simply increase the risks, and any family history of drug or alcohol dependence will increase the risk.
This slide lists the requirements, according to DSM IV, for the diagnosis of substance abuse and in this case opiate dependence. There are seven criteria. You have to have three criteria present at the same time during one 12-month period. Tolerance and withdrawal are going to be present in all of these patients if they are on chronic opiate treatment. The other behaviors all are sort of various reflections of the loss of control that was mentioned earlier, so you only need one of these other behaviors plus tolerance and withdrawal in order to meet the criteria for opiate dependence.
Diagnostic Challenges: Opioid Addiction in Pain Patients on Opioid Therapy

The 4 C's of “Addiction”
• Loss of Control
• Use Despite Consequences
• Compulsive use
• Craving

Savage SR 2002

This is the same slide that you saw earlier.
For the latter part of this talk, I want to look at managing co-occurring addiction in chronic pain patients. Here, I just want to stress again the fact that someone is addicted does not mean they’re ineligible for pain treatment. We certainly see lots of people in our addiction programs that have a great deal of difficulty getting adequate medical care because many physicians really avoid treating them. I think you really need to learn how to manage these patients because the problems are often legitimate and the treatment need is quite real.
Adapting Care for Patients at Risk for Addiction

- Setting of care
  - primary vs. specialty care; team care
- Selection of Treatment
  - Risk/benefit assessment for opioids
  - Adjuvant meds and modalities
- Supply of Medications
  - Weekly? Secured? Supervised?
- Refer for Addiction Treatment
  - Sponsor, family, addiction treatment program
- Supervision and Monitoring
  - Pill counts, drug screens, collateral info.

You do have to consider how you’re going to adapt the care for the patient if there is a risk for addiction. Some of the next slides sort of generously borrowed from Jeff Baxter so he was helpful in putting this information together. First of all, you have to consider the setting, whether you can manage them in a primary care setting or where they need to be referred to a specialty care or pain management program.

Team care is always helpful. If you have a mental health consultant, a psychiatrist, a psychologist, someone who can provide ancillary therapy, you’re probably going to do better by coordinating that care. As has been mentioned, many times you want to do risk-benefits analysis as you assess for opiates. You want to really look first if there’s any real risk and history, are there non-pharmacological ways to treat the problem? If non-pharmacological treatments don’t work, move up to pharmacological treatments but don’t begin with opiates. You want to have a clear risk hierarchy in terms of how you choose the approach for treatment.

You always want to be careful with the supply of medications. As was discussed earlier, in some cases weekly meds are best but that may not be realistic. You do want to monitor them and make sure that they are secured. If there is any real history for addiction, you should consider whether or not you want to refer the patient back for addiction treatment, or at least make sure you know that that’s available, and they know it’s acceptable for them to participate in that treatment. Finally, as mentioned before, direct supervision pill counts, monitoring them, prescription monitoring program.
There are various ways that you can approach managing these patients. In one situation you want to continue the current modality, but you really want to change the structure of care that you’re providing. In that case, you may want to add other pain therapists. You may want to add physical therapy, other approaches to managing the pain. You may want to add mental health treatment and look for a psychiatrist who has experience with addiction and pain. They are not always available, but I think if you can find someone with that experience, it will be more helpful.

Lastly, you might want to consider a pain specialty provider, but as was discussed earlier, that can often be complicated, so you need to be sure what it is you’re looking for and that you’ve accessed someone who’s going to help you manage the patient.
You may need to consider simply increasing the level of care. This slide describes one program that’s been available in one VA where they developed an opiate renewal clinic. Here, this model has actually been quite successful. It’s pharmacy run. They have pain management as part of a team. Patients are educated about pain management and there’s a strong connection to primary care providers. They had over 300 patients who were referred to this clinic in a 2-year period. Over 50% at the time of referral had aberrant behaviors related to their control of pain meds. As you’ll see, over the course of those two years, at least half of those patients improved, so this clinic was really beneficial for the patients who were having difficulty controlling their meds.

About half of the patients that were referred to the clinic did not have aberrant behaviors and they continued to do well over the course of two years. This is a specialized program that certainly any facility that deals with large numbers of pain patients should consider.
You also can look at what you might do with sort of existing programs to try and beef them up in a sense to make them more adequate to manage this type of patient. In a primary care setting, you may want to really increase the M.D. time because you can’t manage these patients with sort of rapid in and out visits. They do take time, and they need to know that you’re concerned about them. That’s very difficult to do if you’re feeling very rushed.

You may want to add nurse care managers. You may want to add psychology care managers; sort of increase your team. You want to make sure that all the providers are well educated about chronic pain management; that you’re all working from the same agenda, that there are treatment plans that everyone is comfortable with. For the patients, they need phone contact information. They need to be educated too about what it is you’re trying to do, what’s the best way to manage chronic pain. You need to make sure that you talk with them about the risks. If they have any psychiatric history or if they’re presenting any psychiatric pathology, you make sure that they understand the appropriateness of screening for depression or anxiety disorders.

If you can integrate group treatment activities or workshops into your general program, that’s particularly helpful and sometimes groups of chronic pain patients are quite useful as ways of expanding the care available to patients and helping them live with their problems and understand how you best can manage the medications. In most of these case settings, I think that this type of increased level of care will result in better outcome, less disability, and improved mental health.
The next few slides are going to talk about managing patients when you decide you have to terminate opiate treatment. There can be a whole range of reasons for this consideration. In some cases, the patient simply is physically better, but they may be physically dependent and you may need to taper them off the medication. In other cases, as Jane described, I think inadequate pain control, lack of efficacy, you finally reach the decision that in a risk-benefit assessment, the risks now outweigh the benefits.

If there is clear loss of control; are there abuse or opiate dependence; and if there is out of control of other drugs. You cannot really safely continue prescribing potent opiates to individuals whose alcoholism is totally out of control or whose benzodiazepine abuse is out of control.
These are categories where you decide you really want to terminate treatment. This may happen involuntarily or it may happen on a voluntary basis. Even with an involuntary withdrawal, I would go slow, stick to a regular schedule, and make sure the patient understands it, and that you really go with it.

In some emergency situations, you may actually have to hospitalize a patient. If the patient is threatening, as was mentioned before, you may want to immediately terminate care. If there is recurrence of pain, and here, I think the most critical thing for the patient and you to understand is terminating the treatment with opiates does not necessarily translate into terminating your treatment; in fact, this will go much better if the patient understands that this is just one element of care that you are planning to change.

If the patient understands that you still have a commitment to work with them, and that there are other ways of managing their pain, and that you’re going to continue to do that, I think you will find it much easier to get them off the opiates. I think the degree to which the patient feels like they’re being abandoned, that is just going to up their level of problems that you’re going to have as you try to taper the opiates. It’s really important that they understand that if pain recurs, you’re going to reconsider things, but there are other approaches for the pain, and that you’re approaching all of this in a more rational way.

I’ll show you an opiate withdrawal scale in a second. I think patients need to know that you’re going to use scales, that you’re going to have a rational way of managing their meds, and that you’re not just doing this in an arbitrary way because you don’t like them and you want to get rid of them, or you want to get them off the meds. I think if they understand that there’s logic to what you’re doing, I think they will relax a little and you’ll find it easier to do.
I think you may expect an increase in psychiatric symptoms as you bring them off of opiates. Opiates in particular are very good antidepressants, and it’s not surprising to see an increase in depression and you may want to consider increasing psychiatric treatment at that time. You also need to understand you don’t tolerate threatening behavior. My experience, however, with most patients, when you begin to get that edge, don’t overreact. I think the more you can be laid back and just make it very clear that threatening, screaming, yelling, is not going to achieve the goals they have and that I can work with you, you don’t need to do that. I think you’ll find that patients are going to be more reasonable.
You want to be very clear that you’re not abandoning the patient. If you do need to terminate treatment, you really need to make sure you’ve clearly documented the reasons. I think you clearly need to document other options where the patient’s been referred for addiction treatment or to other appropriate changes. Make sure you put all of that in writing. As you’re continuing to proceed, particularly if you’re simply just stopping the opiates, again, clearly make sure the patient understands that coming off of meds is not the end of treatment and does not represent your denial of treatment to them.

You may need to see the patient actually more frequently and monitor how you’re doing and being more careful with them. In some sense, I think in the worst case scenarios, giving people lots of pills is an excuse not to see them. In the best case scenario, eliminating the pills and reducing the pills may translate into more care and more frequent care and better attention; that may be the best way to do it, but I think you have to understand that they will interpret that in a way and they’ll understand what you’re doing.
If you’re trying to withdraw someone from opiates, you need to have some sense of which patients are going to have the most difficulty, and you can predict in some cases the severity of withdrawal. Patients who have been on high potency opiates for long periods of time are more likely to have symptoms. Patients who have been on shorter acting opiates are more likely to have symptoms, so you can predict that to some degree.
This slide gives you a sense of the intensity of opiate withdrawal. Here you’re comparing heroin to buprenorphine to Methadone, and you can see that heroin withdrawal, abrupt withdrawal, much more severe, but relatively short acting. Methadone is much longer but less severe. So longer acting opiates are not going to be as severe as the short-acting opiates in terms of withdrawal symptoms, but they will last longer.

For patients who are truly addicted, not just physically dependent, but addicted in the more pathological sense, you’ll find that the slow gradual withdrawal may be the most difficult thing for them to tolerate. Even though symptoms aren’t severe, the lengths of the symptoms are often difficult for them, and they need a lot of support during that time period.
One way to do this is to use clinical opiate withdrawal scales. This is an example of the COWS. This is probably the most commonly used scale. Here, the benefit of this is that it: (1) Gives you a very objective way of measuring severity; (2) It gives you a way of deciding whether you need to treat patients at all; (3) Whether you need to increase the dose; (4) It gives you a target of where you’re going in terms of reducing the severity of symptoms. The major benefit, here again, it’s reassuring to the patient. They know you care. They know you’re tracking things. They know you’re making decisions based on objective evidence rather than just I’m trying to get rid of you and get you out of my office. I would recommend learning how to use scales like this if you’re going to withdraw people and they are complaining of ongoing symptoms.
This slide looks at tapering long-acting opiates. One model is to reduce the medication by 10% to 20% each week. Depending on the formulation of the meds, this may be a little bit more difficult. The rate of decrease may really be determined by how severe their withdrawal symptoms are. You may want to add a supply of short-acting meds for some sort of breakthrough symptoms, so you’re gradually tapering the long-acting opiates and giving them a small supply of short-acting opiates, or give them comfort meds. I’ll show you that in a second.
For tapering individuals who are on short-acting opiates, first of all, you have to consider whether you need to taper at all. The symptoms may be relatively short-lived and you may be able to get them off quite quickly, particularly if there is physiologic presence at all, if there’s physiologic dependence. You may want to decrease the strength of tablets over every week. You may want to do this simply by pill count just to eliminate one pill on a particular schedule.

One option may be to transfer them to a longer-acting opiate. This becomes more complicated. You will have less intense withdrawal symptoms with longer acting opiates, but if you haven’t had a lot of experience doing this, it may be complicated to try and do that.
Another option is to add Clonidine. Clonidine can be used to moderate some of the opiate withdrawal symptoms. Understand that it works best with the physiologic symptoms associated with opiate withdrawal. Clonidine is not particularly effective with psychological symptoms or with craving. So you may have a patient where you’re reducing the physiologic symptoms with Clonidine, yet they still have a lot of cravings, so you need to be prepared for that.

You need to be concerned by hypotensive effects, particularly on an outpatient basis, initial dose of 0.1 mg p.o., monitor blood pressure. I would not go over these recommended limits over 24 hours, so you just need to be careful to not get into difficulty with that. It’s a little easier to manage with the transdermal patch.
This is a list of comfort meds. I won’t go through all of this. I think you’re all familiar with these things, but these are all medications that you can add to help the secondary symptoms of opiate withdrawal. The only things that I would be concerned about are the sleep aids and the benzodiazepines. It’s safe to use them, but you just need to make sure, particularly with the antidepressants for sleep, that the patients are aware that they should not increase the dose beyond what you are recommending. I would really try to avoid benzodiazepines as add-ons at this point in care. I think that could be quite risky to add that in at this stage.

<table>
<thead>
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<th>“Comfort Meds”</th>
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<tr>
<td><strong>Ibuprofen</strong> 600 QID</td>
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<tr>
<td><strong>Dicyclomine</strong> (Bentyl) 20 mg QID for stomach cramping</td>
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<tr>
<td><strong>Pseudoephedrine</strong> 30-60 mg QID</td>
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<tr>
<td><strong>Antiemetics</strong>: Tigan 250 mg po/ 200 mg IM q6-8 hours</td>
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<td><strong>Muscle relaxants</strong>: Robaxin 500-750 mg up to QID</td>
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<td><strong>Antidiarrheals</strong>:</td>
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<td>— Kaolin with Pectin;</td>
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<td>— PeptoBismol (Bismuth HCL)</td>
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<td>— Loperamide (imodium) less effective</td>
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<td><strong>Sleep aids</strong>:</td>
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<td>— Trazodone 50-100 mg</td>
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<td>— Doxepin 25-50 mg</td>
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<td>— Amitriptyline 50mg</td>
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*Note: *Benzodiazepines are highlighted with a question mark to indicate caution in their use as add-ons at this stage.*
Again, sort of the psychological aspects of managing outpatient opiate withdrawal. The patient’s going to be distressed. They are going to need extra support, extra time, extra attention, but you may be surprised in some circumstances to see that their function actually improves as you lower the dose. Reinforce the notion that you’re going to continue to work with the patient. You have other options besides opiates and that you’re not going to abandon them. See the patient regularly to monitor their progress.
Inpatient detox may be an option for some patients, but the current reality is it’s usually relatively short term. It may not have long term benefits. I think that it’s easy to get people off drugs; like opiates, you can do it very quickly in a hospital but the real problem is how they do after they get out of the hospital in preventing relapse. So I would reserve this only for very unsafe patients or patients who are quite unstable.
The last few slides, I want to talk about the option of referring patients to long-term opiate treatment, either Methadone or buprenorphine. In Methadone, you have to get daily doses in the clinic. It’s important to understand that a single daily dose of Methadone is very adequate for controlling withdrawal symptoms and craving, but it does not control pain or no more than 6-8 hours as Dr. Alford went over in his earlier presentation.
Dosing is monitored very carefully. There may be long waits for admission. It may be very disruptive to the patient to attend the clinic every day. Why do we do it? We do it because it works. It’s the most effective control and treatment that we have for opiate dependence. It prevents relapse, reduces extra drug use, shows significant improvement in mental and physical health, and greatly reduces the death rate associated with opiate addiction.
Another option, particularly for chronic pain patients, this may prove to be the more effective option is buprenorphine*. It can be available in an office based setting. It’s a partial opiate agonist. The main advantage with buprenorphine is your ability to fine tune the dose and to divide the dose during the day. Under standard buprenorphine maintenance treatment, patients get a single dose in the morning; however, since they are taking the dose home, they can divide that dose during the day. We’ve discovered with a number of chronic pain patients that buprenorphine provides adequate control of both their pain symptoms and it eliminates the addiction symptoms.

I think that over the next few years, we’re probably going to see an expanded practice role for buprenorphine for dealing particular with the more difficult patients with legitimate chronic pain and clear cut history of addiction. It’s available in sublingual tablets, and now a sublingual film strip only in two doses, 8 mg and 2 mg. Providers need 8 hours of training in order to prescribe buprenorphine, but it’s been highly effective in a large number of difficult patients. I would strongly encourage any of the primary care physicians here who work with these patients to get the training to use buprenorphine. I think you’ll find it’s worthwhile.

*Off-label use.
Just a few caveats; if you’re referring patients to opiate agonist therapy, either Methadone or buprenorphine, as standard practice, that is single doses of Methadone, single daily doses of buprenorphine; that is not adequate for patients with real pain control. The legal constraints on Methadone dispensing in clinics makes it very difficult to manage pain patients in that particular setting. It’s important to recognize that neither of these drugs treats other addictions besides opiate dependence.

They don’t treat alcoholism. They don’t treat cocaine dependence. They don’t treat benzo dependence. You may need to supplement with other opiates if patients are on buprenorphine or Methadone. Patients on Methadone and buprenorphine develop tolerance. They may develop new pain syndromes. They may need extra management of those symptoms for conditions that occur. It’s not easy to directly transfer patients. From buprenorphine, you have to be in opiate withdrawal before you get the first dose, and with methadone you have to build up the Methadone dose very slowly and there may be a long wait before you can get into a Methadone treatment.
This slide just gives you some references for finding treatment. SAMHSA has a treatment facility locator on their website; Massachusetts State Hotline; Buprenorphine Treatment, sort of references of Massachusetts Hotline there and the SAMHSA Hotline and lastly, the National Alliance of Advocates for Buprenorphine Treatment, that final website also has referral information and information for patients. I think we’ll stop now for questions. Thank you.

[Applause]