PCSS
Providers' Clinical Support System
Monthly Update
July 2015

Inside

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Treating Chronic Pain Without Opioids

by Beth Darnall, PhD

People with chronic pain often focus on opioid therapy for two reasons: (1) they believe it's the only treatment that is effective, and (2) rarely do they understand the risks and consequences of long-term opioid use.

Opioids in isolation are poor treatment for chronic pain. Opioids may be one part of an overall care plan that is much more focused on self-management, setting functional goals, appropriate exercise and rehabilitation, sleep hygiene, stress management, and pain psychology. The goal is to best manage pain with other approaches to ensure that the least amount of medication is needed. Less medication = fewer risks. Also, when medication is de-emphasized, it allows the other evidence-based treatment options to come into focus. Ideally, opioids are not used at all, as research suggests that in the long term they work well only for a minority of patients with chronic pain. In fact, opioids can create secondary problems, such as hypogonadism. Lowered sex steroids interferes with mood, libido, and fertility. Opioids are known to disrupt sleep architecture, thus reducing restorative rest and contributing to daytime fatigue. Some research suggests that over time, opioids contribute to hyperalgesia, thereby worsening the problem they are supposedly treating. Unintentional opioid overdose deaths have become a national epidemic, and a substantial proportion of patients die because they are prescribed opioids in combination with benzodiazepines—a risky combination that compounds the respiratory depressive effects of opioids alone. Elderly patients are at greater risk for falls and fractures when taking opioids. These are just some of the risks associated with prescription opioids.

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Notably, none of these risks involve addiction, another issue entirely. The majority of patients taking opioids will have dose increases over time when tolerance develops, thus increasing their opioid risks. Few patients are aware of the risks and limitations of opioids, or that by taking opioids they may be unwittingly increasing their pain.

Nobody wants to take opioids—they just want less pain! Opioids are not recommended for many pain conditions, however, such as irritable bowel disease, migraine, headache, or chronic low back pain. Pharmacologically, non-opioid pain medicines are best for these conditions. And with that said, patient empowerment is cultivated outside of the pill bottle.

As a main method for reducing reliance on medications, it is important to understand the power of pain psychology and how patients can harness the power of their nervous system to lessen suffering. Without this critical information, physicians may be partially and unwittingly prescribing opioids to treat cognitive, emotional, behavioral, and physiological factors—all aspects of a person's life.

Key messages physicians must tell people with chronic pain:

(1) **Your brain can amplify your pain.** Your brain processes pain signaling, emotions, and emotions through shared networks. For this reason, the patients' thoughts and mood have the capacity to amplify pain processing in their brain and entire central nervous system. In other words, how patients feel emotionally impacts what they feel in their body. This is the mind-body connection, and patients can learn to use it to their advantage.

(2) **How patients respond to pain is a critical and overlooked factor.** While pain is medically-based, the patient's responses to pain and to his or her everyday life stress will dial pain up or it will dial it down.

(3) **Reclaim control over pain with specific skills.** Learning specific skills and techniques will enable patients to dial back their pain and therefore help patients need and use less pain medication. Patients will learn how to self-regulate their thoughts, emotions, and physiological responses so that they are no longer amplifying their pain experience behind the scenes. Pain psychology skills work best when used daily or several times daily. The biggest mistake people make is that they use them infrequently and never accumulate lasting results.

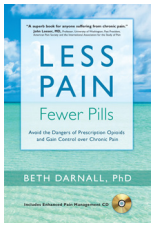
(4) Pills alone are a bad plan! While medications (and even opioids) may be one part of a successful, interdisciplinary pain management plan, relying on opioids alone is a poor strategy and can set a patient up for serious problems including side effects, tolerance, addiction, fertility concerns, and even worsening pain. Quite simply, it puts the pills in control instead of the patient. Avoid this mistake.

(5) **Know your patient's specific opioid risks.** Opioid risks vary by age, sex/gender, and comorbidities. Know your patients' specific risks so that they can make informed medical decisions, be vigilant in monitoring themselves for problems, and minimize their use of opioids by focusing on non-opioid pain management strategies.

(6) **Opioids are not helpful for many conditions and may make pain worse.** Substantial research confirms that opioids are NOT effective for migraines, irritable bowel disorder, chronic low back pain, or fibromyalgia. Furthermore, opioids may make things worse by undermining patients' sleep quality and altering hormone levels. There may be other types of pain medication that can be helpful for patients, however, so learning about alternatives is important.

(7) **Exercise is one of the best treatments for chronic pain.** Patients should get a physical therapy evaluation and begin a program that's appropriate for their level. Exercise helps rehabilitate the body, and it supports good mood, improved sleep, and renewed confidence in your patients as they begin to notice functional gains and goal attainment.

(8) **Give your patients resources, such as the American Chronic Pain Association (ACPA) website for information and resources for managing chronic pain.** The ACPA offers online self-paced classes to get patients moving toward their goals. Excellent chronic disease self-management courses are available across the U.S. and world: http://patienteducation.stanford.edu/organ/ Empowerment begins with education. Transformation begins with action.



Dr. Beth Darnall is Clinical Associate Professor in the Department of Anesthesiology, Perioperative, and Pain Medicine at Stanford University. She is author of Less Pain, Fewer Pills: Avoid the dangers of prescription opioids and gain control over chronic pain © 2014, a patient empowerment book that includes opioid education, pain psychology skills, and a free binaural audio CD. Her NIH-funded research and advocacy work focuses on broadening access to effective, low-cost pain treatments. In 2015 she received a Presidential Commendation from the American Academy of Pain Medicine. Read more at www.bethdarnall.com.

What Price Would *You* Put on this Family's Health?

Treating Patients With Opioid Use Disorders is More Rewarding Than You Might Think.

Providers' Clinical Support System for Medication Assisted Treatment can help you treat patients with opioid use disorders with confidence using evidence-based criteria. Our clinical experts are available to give you guidance on these complex, but worthy, patients.

PCSS-MAT offers at no cost:

- Live and archived webinars
- Mentoring
- Buprenorphine waiver training
- Case vignettes
- Online modules
- Clinical resources
- Small group discussions
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P C S S MAT TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

PCSS Projects Training Healthcare Providers Throughout the Country

PCSS Projects have been busy this year conducting live trainings throughout the country in response to requests from a variety of organizations. The following is a run-down on the activities already conducted in 2015 and some that are scheduled for the near future.

- On June 1, Drs. Michelle Lofwall and David Fiellin conducted a training in southern Indiana in response to the opioid overdose and HIV epidemic fueled by needle sharing.
- On June 6, the American Academy of Addiction Psychiatry, in collaboration with the Rhode Island Dept. of Health, the RI Dept. of Behavioral Healthcare, Developmental Disabilities and Hospitals, Southeastern Consortium for Substsance Abuse Training and Butler Hospital, conducted a half-day training. Paul Seale, MD, provided the training to physicians, health professionals, and dentists.
- On June 13, Ellen Edens, MD, gave a one-hour presentation to the New York chapter of the American Academy of Neurology's annual meeting.
- Paul Seale, MD, is scheduled to present at the Mississippi chapter of the American Academy of Family Physicians' Annual Scientific Assembly held in Florida, July 20.
- Steve Wyatt, MD, is scheduled to present Sept. 18 to the Missouri Department of Mental Health Physician Institutes' Community Behavioral Health Conference.
- On Oct. 22, Sharon Levy, MD, is presenting at Grand Rounds at Primary Children's Hospital in Salt Lake City and conducting a training targeting pediatric residents for the Utah Chapter of the American Academy of Pediatrics. She will speak on *National Trends and Evidence-Based Pediatric Practice for Preventing Misuse and Addiction of Opioids*. The training will be presented live before residents and will also be available throughout the state via videoconference.
- On Nov. 6, Robert Swift, MD, will speak on *The Treatment Team Approach to Opioid Dependence Treatment* before the Addiction Professional Summit in Rhode Island.

Many other trainings and presentations are in development. If your organization and/or medical association has need for a training, please contact the PCSS Project team at 401-524-3076 or email Jane Goodger and we will do our best to accommodate your request. In-person trainings are not always possible, but hundreds

AAPM's Trainings All Available as Enduring CME Sessions

American Academy of Pain Management (AAPM) is now offerings its PCSS-O Year One programming as archived CME sessions. The series of three, opioid-related educational webinars featuring AAPM Past President Lynn R. Webster, MD, include: *Best Practices: Eight Principles for Safer Opioid Prescribing for Pain Management; Guide to Aberrant Drug-Related Behavior When Prescribing Opioids for Pain Management,* and *Responsible Prescribing*

AMERSA Releases Special Edition of Substance Abuse Journal

The **Association of Medical Education and Research Abuse (AMERSA)** recently released its special issue of the *Substance Abuse Journal*, "Expanding Treatment for Opioid Use Disorder: The Role of Pharmacotherapies."

This special edition, made possible through a PCSS-O mini-grant, is now available online; several of the articles are free with open access. Hard copies are available to subscribers and authors.

Please access the online journal here.

Announcements and Educational Opportunities

If you have an educational resource or training on opioid use disorders that you would like to share contact: jane@aaap.org.

Please limit to 400 words.

Trainings

PCSS-O Upcoming Webinars
PCSS-O Archived Webinars
PCSS-O Online Modules

PCSS-MAT Upcoming Webinars
PCSS-MAT Archived Webinars
PCSS-MAT Online Modules

Upcoming Buprenorphine Waiver Trainings

Small Group Discussions

PCSS-O

What is the Appropriate Length of Buprenorphine Treatment?
Wednesday, July 15, 2015, 12:00 - 1:00 pm ET
John Renner, MD

PCSS-MAT

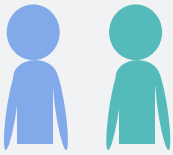
Determining the Most Appropriate First Line Treatment for Opioid Dependency
Wednesday, August 5, 2015, 12:00 - 1:00 pm ET
Alan Wartenberg, MD

Note: These programs are designed as a coaching session on clinical issues. Invitations are sent to those already enrolled in PCSS-MAT Mentor or PCSS-O Colleague Support programs at least three weeks prior to the event. Learn more by emailing Seth (PCSS-MAT) or Justina (PCSS-O).

Case Study: What would you do?

You provide treatment in a large, community psychiatry clinic. The program started office-based buprenorphine treatment several months ago, and you volunteered to be the primary physician for this new service. The nearest methadone treatment program is more than an hour away from the clinic, and several opioid-dependent patients have been referred to the clinic for office-based buprenorphine treatment. Your first patient is a 34-year-old woman who started buprenorphine treatment nearly 3 months ago. You selected her for several reasons: she only used heroin, she is employed, her husband does not use drugs, and she was motivated and informed about buprenorphine.

Read the complete case study



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