Intersection of Addiction & OAD
3rd June 2015

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Declaration of Interests / Funding

- Edinburgh & Lothians Health Foundation Alcohol Problems Endowment Fund – contribution to MSc in Pain Management
- Astellas Pharma Ltd – funding to attend BPS annual scientific meeting (2014)
- Reckitt Benckiser – funding to attend Opioid Painkiller Dependence Education Nexus (September 2014)

Overview

• Addictions, pain & mental health – what are the links?

• The risks of addiction – how can we assess?

• Models of service
Addictions, pain & mental health – what are the links?
Prevalence of Chronic Pain

Chronic pain of moderate to severe intensity occurs in 19% of adult Europeans, seriously affecting the quality of their social and working lives.

British Pain Society- one in seven of UK population
Opioid Analgesic Use

- Trends in prescribing

- Increasing prescribing of opioids, in particular of strong opioids, in Scotland

Access to pain relief – an essential human right
IASP, the WHO and EFIC

- The UN Universal Declaration of Human Rights conceptualises human rights as based on inherent human dignity

- Perception and expression of pain is individual:
  - It is essential to listen to and believe the patient – only they know what the pain feels like

(A report for World Hospice and Palliative Care Day 2007 Published by Help the Hospices for the Worldwide Palliative Care Alliance)
Drug & alcohol use in Scotland

- Estimated prevalence of problem drug use (opiates and/or benzodiazepines) Scotland 2012-13 of 1.68% population aged 15-64 (ISD, Scotland)
- Up to 50% men and 30% women across Scotland exceeding weekly recommended guidelines (Changing Scotland’s Relationship with Alcohol: A Framework for Action, 2009)
Mental health

• 19% of people aged 16 or over in UK experience anxiety or depression (mild mental health problems)

• Higher if divorced / separated / not in paid work

Office for National Statistics, 2013
Depression & pain

• 65% of patients with depression experience one or more pain complaints
• Depression is present in 5% to 85% (depending on the study setting) of patients with pain conditions
• Pain modulation is affected by depression

Increased psychopathology in patients with chronic pain

- Depressive disorders
- Anxiety disorders
- Somatoform disorders
- Substance use disorders
- Personality disorders

Pain and Suicidality

• Increased suicidality in pain patients

• Relationship with reward / anti-reward pathways

Pain & Psychiatry

- Neuroanatomical & functional overlap of pain with emotion / reward / motivation circuits
- Pain processing affected by psychiatric disorders / emotional & neurocognitive functions affected by pain

Licensed Treatments

- Amitriptyline – depression & neuropathic pain
- Duloxetine – depression, generalized anxiety & diabetic neuropathy
- Pregabalin – peripheral / central neuropathic pain & generalized anxiety
- Carbamazepine – trigeminal neuralgia, prophylaxis of bipolar disorder

PSYCHOLOGICAL INTERVENTIONS
Not just “painkillers” for pain

- Physical pain predicts lapse to heavy drinking during and after treatment

The risks of addiction – how can we assess?
Increase in prescription opioid use in US

- “Non-medical use of prescription opioids has increased over threefold since 1990”
- “Research has long demonstrated that patients with no prior history of opioid abuse treated with opioid pain medications over extended periods do not experience euphoria—these patients are therefore unlikely to become addicted”

Why do patients misuse prescription opioids?

- Increased negative affect increases risk of prescription opioid misuse
- Relationships between negative affect, pain intensity and prescription opioid misuse using COMM questionnaire

Factors that may predispose to abuse of opioid medication

• Previous substance misuse
• Family history of substance misuse
• Psychiatric disorder
• Ongoing pain
• Aberrant behaviours
• Psychosocial factors, including unemployment
Aberrant behaviours

- Selling prescription drugs
- Prescription forgery
- Concurrent abuse of related illicit drugs
- Obtaining prescription drugs from nonmedical sources
- Stealing or borrowing another patient’s drugs
- Injecting oral formulation
- Drug hoarding during periods of reduced symptoms
- Reporting psychic effects not intended by the clinician
- Recurrent prescription losses
- Multiple unsanctioned dose escalations
- Requesting specific drugs
- Unsanctioned dose escalation 1–2 times
- Unapproved use of the drug to treat another symptom
- Acquisition of similar drugs from other medical sources
- Aggressive complaining about need for higher doses

Open slide, 2014
Possible Tools

- COMM
- ORT
- SOAPP
- SOAPP-R
- SISAP
- DAST-10
- Prescription abuse checklist
- PDUQ
- STAR
- PADT
- PMQ
- DIRE
- Addiction Behaviours Checklist (ABC)
- POMI
- PODS
- Screening Tool for Abuse

Models of service
Depends on patients – broad groups from Lothian Pain and Dependency (PAD) clinic

- “Established” drug users with pain (often on substitute prescriptions). Pain often a result of chaotic lifestyle
- Pain resulting from alcohol dependence
- Concerning use of over the counter or prescribed medication (usually opioids, but may be other drugs, eg gabapentin)
- Past history of drug or alcohol use
Substance misuse patients

- Increased prevalence of pain

- Poorer treatment outcomes. Yet treating pain improves outcomes

- More likely to use illicit opioids / more drug-seeking

- Often stigmatised
Lothian PAD

- Increasing referrals of complex patients on prescribed opioids
- Concerns regarding accessibility by “substance misuse” patients
- Other groups with potential difficulty accessing care – hospital inpatients, prisoners, palliative care patients
Potential Models

• Where should services be based?
• Links with other services (psychology, physiotherapy, psychiatry, non-stat services, self help, peer support…)
• Access to pain management services
• Access to inpatient beds / day services
• Liaison models
• Multidisciplinary care