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PAIN AND THE OPIOID EPIDEMIC

AN INTERIEW WITH LUANA COLLOCA, MD, PhD, MS

By

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The so-called "opioid epidemic" is a far more complex social phenomenon than it appears to be when politicians and pundits propose solutions to it. They work largely from a simplistic and only partially true narrative that lately concludes that the villains are the drug companies that promoted inappropriate and dangerous use of prescription pain killers. In an earlier formulation, doctors were the villains. Both, of course, have been sadly critical contributors to growing addiction and overdose deaths, but they are not nearly the whole of it.

The narrative goes something like this: the increasing drug overdose deaths in the 21st century, though mostly not from prescription pain killers, reflect a progression first from using prescribed opioids for pain or using stolen painkillers to get high to—second—becoming addicted, to—third—using easily accessible and cheap street heroin (sometimes laced with fentanyl) to—fourth—accidental* overdose deaths (Gladden, O'Donnell, Mattson, & Seth, 2019).

This narrative neglects the facts that (1) many overdose deaths involve the use of multiple drugs—especially alcohol and benzodiazepines (Sun et al., 2017), (2) the growth of overdose deaths over the past few years is almost entirely due to street fentanyl, (3) many deaths are from adulterated street drugs, (4) it seems likely that the increased demand for drugs—and consequent rise in deaths—is fueled not just by their availability but by unclear social factors that are driving a rising sense of despair, which has led to increased suicides and alcohol-related deaths as well as increased drug overdoses (Case & Deaton, 2015) and (5) the management of acute and chronic pain remains challenging.

Given the complexity of the opioid epidemic (Dowell, Compton, & Giroir, 2019), solutions need to be a comprehensive combination of interventions including (1) control of the manufacture, distribution, prescription, and illegal sale of drugs, (2) use of preventive interventions at both the community and individual levels, (3) improved access to effective treatment

* Some of these overdose deaths are probably purposeful. Research is now going on to try to identify those that are suicide.

of addiction, including treatment with medications, and (4) more widespread use of life-saving emergency interventions by first responders.

One component of all this is effective pain management.

We are very lucky that Luana Colloca, MD, PhD, MS, an international expert on the neuroscience and treatment of pain, has agreed to talk with us about how the approach to pain management needs to change to effectively manage pain without creating risk of addiction and its consequences. Our conversation about opioids and pain management focused on eight questions.

Question 1: Based on your research, are opioids a reasonable medical response to physical pain?

The use of opioids for the treatment of pain can put patients at high risk for opioid misuse, abuse, and addiction. They should very rarely be used for chronic pain. And even though they can be useful for acute pain, there are effective and less risky alternatives for some patients. Opioids are often a reasonable treatment of pain associated with terminal illnesses, although some patients prefer not to use them so as to remain as alert as possible as long as possible.

Unfortunately, medical professionals have been trained to use opioids far too frequently. There need to be major changes in the way pain management is approached.

Question 2: What changes do you think are necessary?

First, the current, virtually universal approach to evaluating pain is fundamentally misleading. Medical practitioners ask patients to rate their pain from 1-10. The result is a highly subjective evaluation of pain that does not capture the complexity of the pain experience including interfering with daily activities and creating emotional burdens (Pattullo & Colloca, 2019). For example, one person on the verge of tears because of their pain may rate it a 6 while another will rate it 10. Not very informative.

There are tools for rapid evaluation of pain that are far more useful. (Gordon D. 2015)

Medical and dental practitioners are trained for the most part to use opioids for the immediate and short-term treatment of acute pain. Instead, health care providers should be trained to do a rapid individualized assessment of functional pain and then to select individualized pharmacological and non-pharmacological interventions that may or may not involve the use of opioids even for acute pain.

Fortunately, there is a clear trend not to use opioids for the treatment of chronic pain (Dowell et al., 2019; Wood, Simel, & Klimas, 2019). Hundreds of thousands of people are now being tapered off the opioids they may have used for years and are managing pain in other ways.

Question 3: Could you say something about the rapid evaluation tools?

I do want to emphasize that these evaluations can be done very rapidly, even in the emergency room for people who are in very severe pain. The fundamental questions are:

(1) How bad is the pain? Or in the case of post-surgical pain, how bad will it be? Not a number, but how does or will the patient experience it. Totally intolerable, really hard to take, bad but I can think and communicate.

(2) How does it affect functioning? There's a functional pain scale that can be rapidly administered to a conscious patient.

(3) How much does pain interfere with one's life? There's also a tool to capture this.

Of course, it's also important to ask about the patient's experience with managing pain in the past.

The key is to use this basic information to **tailor an individualized plan.** Pain management, that is, needs to become one form of "precision medicine", which increasingly is the hope for vast improvements in treatment for many medical conditions.

Question 4: You have said that there are pharmacological and non-pharmacological interventions that can effectively manage pain without the use of opioids. What are the preferable pharmacological interventions?

The pharmacological interventions include both prescription and over-the counter drugs. For example, non-steroidal anti-inflammatory drugs (NSAIDS) can be very effective as can Tylenol and other pain relievers that are not anti-inflammatory drugs. As with all drugs, of course, there are potential side-effects of NSAIDS and other pain relievers that need to be watched carefully.

Also, it is very important to keep in mind that **emotions play a very important role in a patient's experience of pain**. For example, anxiety about how bad pain will be makes the experience of pain worse. Emotional aspects of pain can be assessed by using the specifiers from the recent International Classification of Diseases (ICD-11) for pain (Treede et al., 2019)

Drugs that reduce anxiety can be helpful to some patients. Of course, all of these drugs need to be used with care. Benzodiazapines combined with opioids, for example, are a major contributor to drug overdose deaths. Anti-depressants and beta-blockers can have distressing side effects.

Most important, again, is to tailor the choice of medications to the patient's experience.

Question 5: You have mentioned tailoring twice now. Could you say a bit more about why it is important to individualize pain management?

There are a number of different types and causes of physical pain. Neuropathic pain, for example, is different from acute pain, and it responds to different forms of treatment (Gladden et al., 2019). In addition, pain may be due to trauma, such as broken bones, to surgery, to arthritis, cancer, diabetes, neurological damage, spinal conditions, shingles, etc.

It is critical to understand the type and source of pain in devising a chronic pain management plan. There are a number of medications, such as gabapentin and some anti-depressants that are frequently prescribed instead of opioids. They are effective for some types and causes of pain but not for others (Colloca et al., 2017). And some patients are troubled by side-effects such as sleepiness and sexual dysfunction. Again, **individualized choices based on a good evaluation are the key to effective pain management**.

Question 6: You have said that there are non-pharmacological interventions that can be helpful. What are they?

Non-pharmacological interventions can be useful both alone and in combination with pharmacological interventions (Garland et al., 2019). They include exercise, acupuncture, physical therapy, etc. on the physical side and counseling on the psychological side.

It is critical to understand that the experience of pain is not caused exclusively by physical conditions. Attitudes towards pain, optimism about life, engagement in pleasurable and meaningful activities and relationships, all have an impact on the experience of pain. Counseling of various kinds can help people to overcome demoralization (Friedman and Nestadt, 2013) about their physical condition and can help them to be as active and involved as their physical condition permits.

Again, tailoring is key. And **tailoring needs to address the psychological, social, and spiritual dimensions of a person's life as well as the physical sources of pain**.

Question 7: Over the past couple of years concerns have been raised—by me among many others—that changing practices regarding the use of

opioids may result in some people not getting the pain relief they need. Do you think that opioids should be used for some people who otherwise experience unrelenting pain?

There is no doubt that for some people opioids are necessary to treat pain effectively. There is also no doubt that they are over-used. It's also interesting that some people with terrible pain choose not to take opioids because they don't like the effect that it has on their cognitive capacity and perception of reality.

So, yes, sometimes opioids are the treatment of choice, but pursuant to a pain management plan that is—to say it again—tailored to the individual.

Question 8: This has been quite fascinating. I'd like to conclude by asking you what changes in health and behavioral health policy are important to move to a more informed and precise practice with regard to pain management without reliance on opioids.

There are a number of key changes that are needed.

(1) Policy makers need to understand that the opioid epidemic is a complex, multi-dimensional problem that needs a multi-dimensional response.

(2) Regulations, standards, and practice guides should emphasize prevention of opioid addiction by using opioids only rarely and in accordance with an individualized pain management plan. The expectation should be that pain—other than the pain associated with terminal conditions—should be treated without opioids.

(3) Effective pain management requires multi-disciplinary interventions. The move to comprehensive delivery systems that include physical, behavioral, and dental care can contribute to improved pain management.

(4) The goal should be for pain management to become part of the enterprise of precision medicine—personalized, tailored treatment.

(5) Training and education of clinicians—medical, behavioral, and dental—needs to change, emphasizing meaningful evaluation and tailored multi-dimensional pain management interventions.

(6) This will depend on more effective translation of research into practice. There needs to be more funding for this to take place.

(7) Finally, pain management remains a great challenge. We researchers are far from having all the answers we need to be able to fully tailor effective interventions. More research will be

absolutely essential to ultimately be able to manage pain without causing addiction or other unfortunate outcomes. NIH's billion-dollar investment this year is a great first step. It will need to continue.

Thank you Dr. Colloca. Your comments have been illuminating and have created a challenge for all of us in the field of behavioral health as well as for medical and dental personnel.

(Luana Colloca, MD, PhD, MS is an NIH-funded associate professor at the University of Maryland and an honorary professor at the University of Sydney School of Psychology.

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References:

Case, A. and Deaton, A. (2017). Mortality and Morbidity in the 21st Century. *Brookings Papers on Economic Activity*, Spring 2017.

Colloca, L., Ludman, T., Bouhassira, D., Baron, R., Dickenson, A. H., Yarnitsky, D., . . . Raja, S. N. (2017). Neuropathic pain. *Nat Rev Dis Primers, 3*, 17002. doi:10.1038/nrdp.2017.2

Dowell, D., Compton, W. M., & Giroir, B. P. (2019). Patient-Centered Reduction or Discontinuation of Long-term Opioid Analgesics: The HHS Guide for Clinicians. *JAMA*, 1-3. doi:10.1001/jama.2019.16409

Friedman, M and Nestadt, P (2013). Depressed or Demoralized. *Huffington Post*, April 2013.

Garland, E. L., Brintz, C. E., Hanley, A. W., Roseen, E. J., Atchley, R. M., Gaylord, S. A., . . . Keefe, F. J. (2019). Mind-Body Therapies for Opioid-Treated Pain: A Systematic Review and Meta-analysis. *JAMA Intern Med*. doi:10.1001/jamainternmed.2019.4917

Gladden, R. M., O'Donnell, J., Mattson, C. L., & Seth, P. (2019). Changes in Opioid-Involved Overdose Deaths by Opioid Type and Presence of Benzodiazepines, Cocaine, and Methamphetamine - 25 States, July-December 2017 to January-June 2018. *MMWR Morb Mortal Wkly Rep, 68*(34), 737-744. doi:10.15585/mmwr.mm6834a2

Gordon, DB (2015). Acute Assessment Tools: Let Us Move Beyond Simple Pain Ratings. *Current Opinion in Anesthesiology*: October 2015 - Volume 28 - Issue 5 - p 565–569 doi: 10.1097/ACO.0000000000000225

Pattullo, G. G., & Colloca, L. (2019). The opioid epidemic: could enhancing placebo effects be part of the solution? *Br J Anaesth, 122*(6), e209-e210. doi:10.1016/j.bja.2018.11.027

Sun, E. C., Dixit, A., Humphreys, K., Darnall, B. D., Baker, L. C., & Mackey, S. (2017). Association between concurrent use of prescription opioids and benzodiazepines and overdose: retrospective analysis. *BMJ, 356*, j760. doi:10.1136/bmj.j760

Treede, R. D., Rief, W., Barke, A., Aziz, Q., Bennett, M. I., Benoliel, R., . . . Wang, S. J. (2019). Chronic pain as a symptom or a disease: the IASP Classification of Chronic Pain for the International Classification of Diseases (ICD-11). *Pain, 160*(1), 19-27. doi:10.1097/j.pain.0000000000001384

Wood, E., Simel, D. L., & Klimas, J. (2019). Pain Management With Opioids in 2019-2020. *JAMA*, 1-3. doi:10.1001/jama.2019.15802