Prescribing practices that can create iatrogenic addiction

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Wednesday 03/03/21, 7pm - 8.30pm

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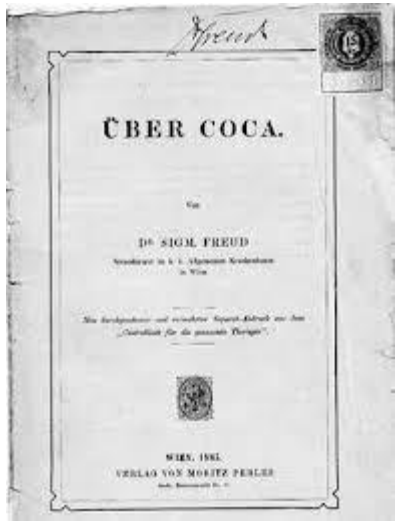
Roadmap

The risks of pushing quick fixes at an industrial-scale.

Introducing positive approaches in time-poor general practice while withdrawing (or not initiating) addictive pharmacotherapy.

The health industry routinely pushes drugs with potential iatrogenesis.



Medicinal nicotine: Nicotine patches. Vaping now being pushed heavily.

Medicinal cannabis: >150 indications. Australia legislation by-passed the TGA. Cannabidiol (CBD) is proposed to be OTC at pharmacists.

Medicinal alcohol: hypnotic (before bromides); hand-wash + “non-beverage alcohol”, anaesthesia.

Medicinal barbiturates: hypnotics (post bromides), epilepsy, anaesthesia.

Medicinal LSD: 1960’s research indicated a role in alcohol dependency and schizophrenia.

Medicinal ketamine (“Special K”) anaesthesia, pain and depression.

Medicinal ecstasy: emerging role in PTSD, couples therapy and Parkinson’s.

Medicinal cocaine: used as a local anaesthetics. Promoted by Freud.

Medicinal amphetamines: ADHD, narcolepsy

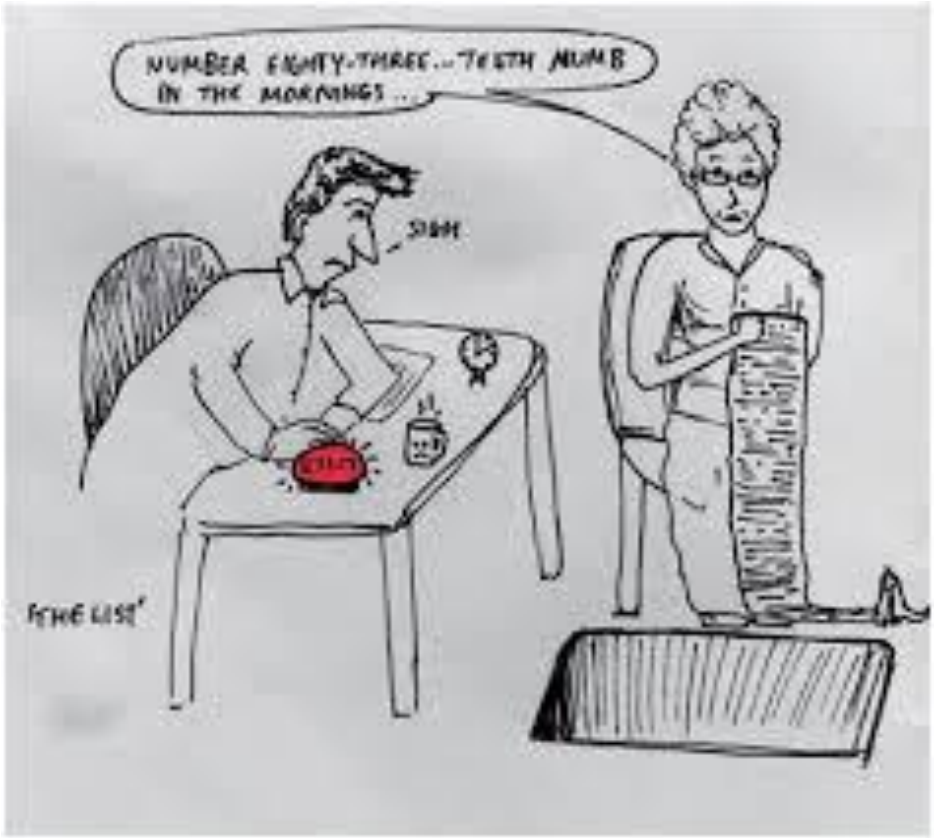
Medicinal opioids: used for everything

Medicinal downers: benzos, z-drugs, quetiapine: used for alcohol withdrawal/pall care/a better life

Multi-morbidity: heartsink patients

Requests for pain-killers or sleepers rarely involve the first issues raised.

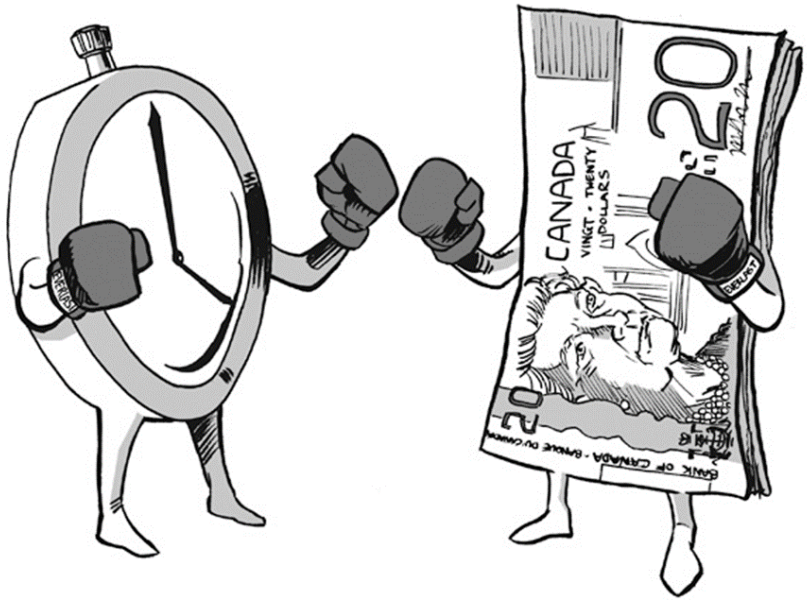
These complex patients require our time, continuity of care and “Chronic Disease Model” strategies …



Time and money pressure may work against us

Swap these time and money pressures around.

- Refusing scripts without consultations allows more frequent consultations
- Ensure the MBS items for complex care are systematically utilised



Plan time and resource efficient strategies

- Have a practice policy ensuring continuity of care with one doctor only for patients on S8’s or benzos.
- Put up a sign in the waiting room about your medication policy

Insert the name of your clinic here.

Pain-killer & sleeping pills policy (e.g. oxycontin, morphine, valium)

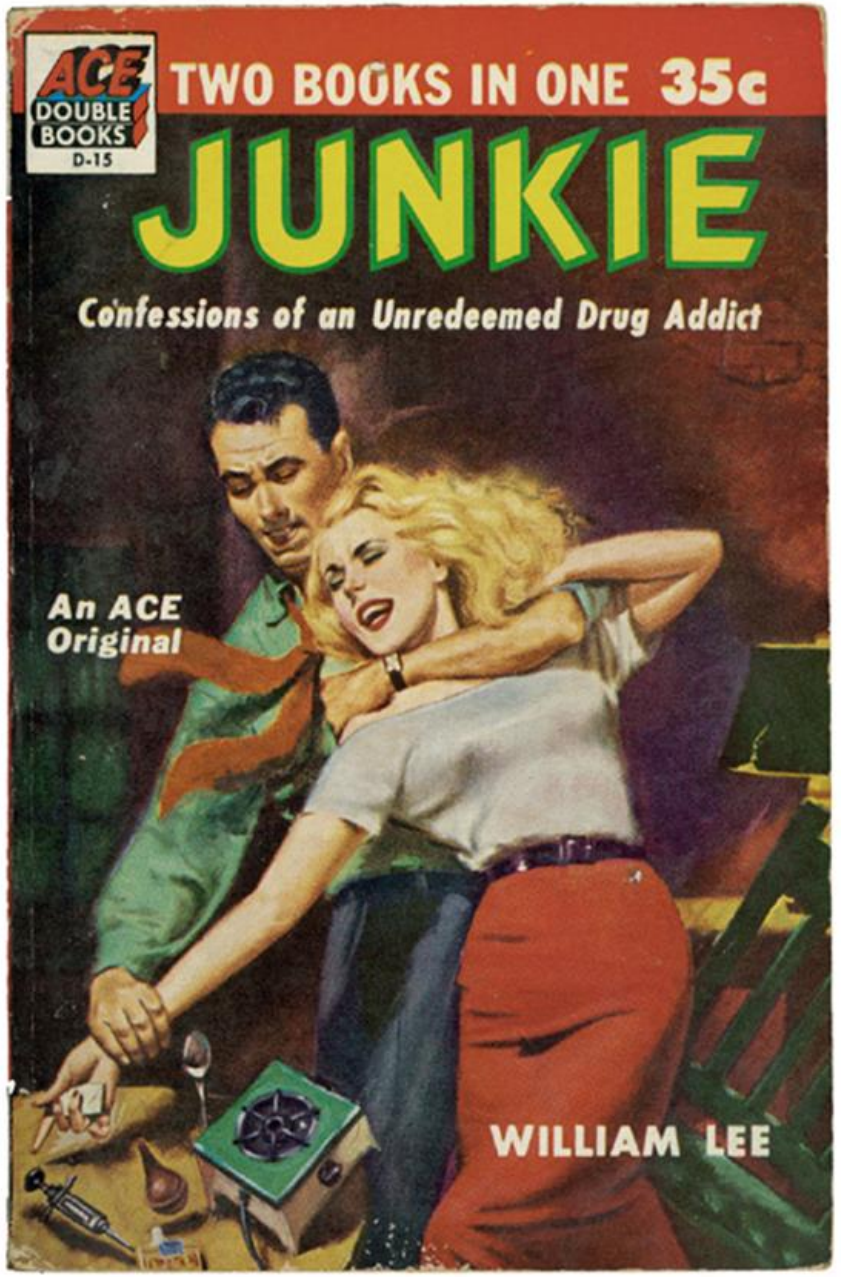
Except for terminal cancer, our policy is that we will not prescribe these medicines:

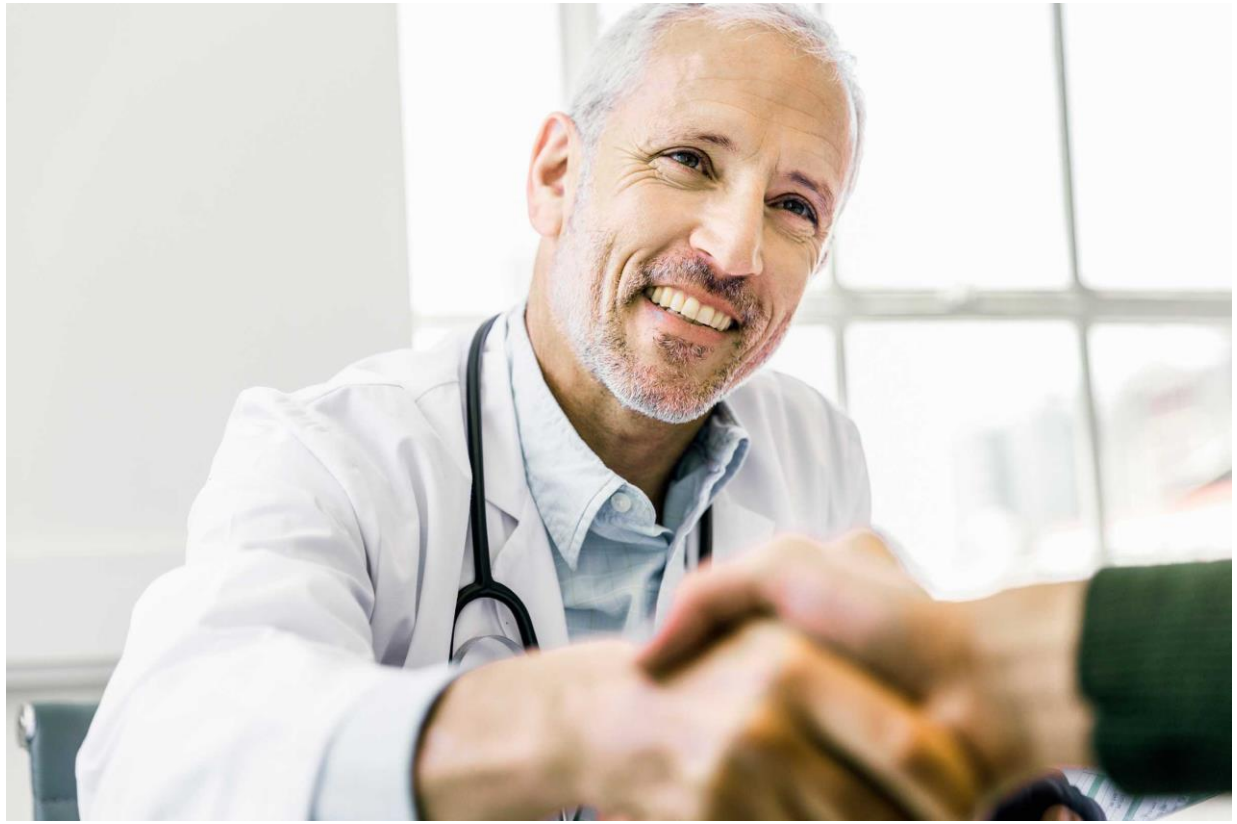
- at your first appointment with any doctor.
- for a phone request.
- without a proper assessment.
- over the long-term (we prefer safer and better options).

Quality chronic pain care and/or quality addiction care

Regulators, Big Pharma and we as clinicians all want to create a simple and satisfying moral dichotomy between genuine pain patients and (presumably) genuine drug addicts.

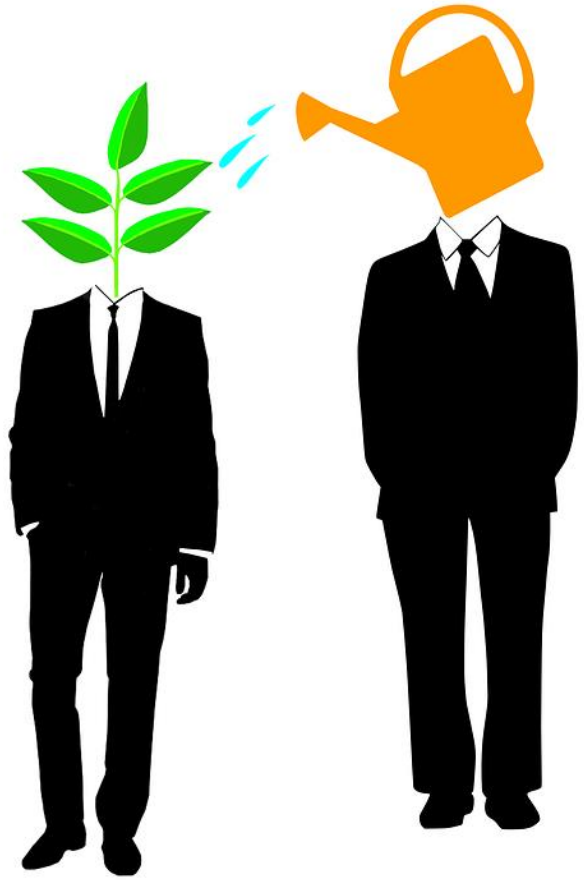
"The misattribution of the opioid crisis to nonmedical abuse rather than to addiction has stymied efforts to address this crisis." (Kolodny et. al. 2015 Ann Rev Pub Health)





- Doctors love our role of solving people’s problems.
- People come to us because they need us to fix their problems.
- But our opioids and benzos are failing to resolve the disability of chronic pain, anxiety or insomnia.

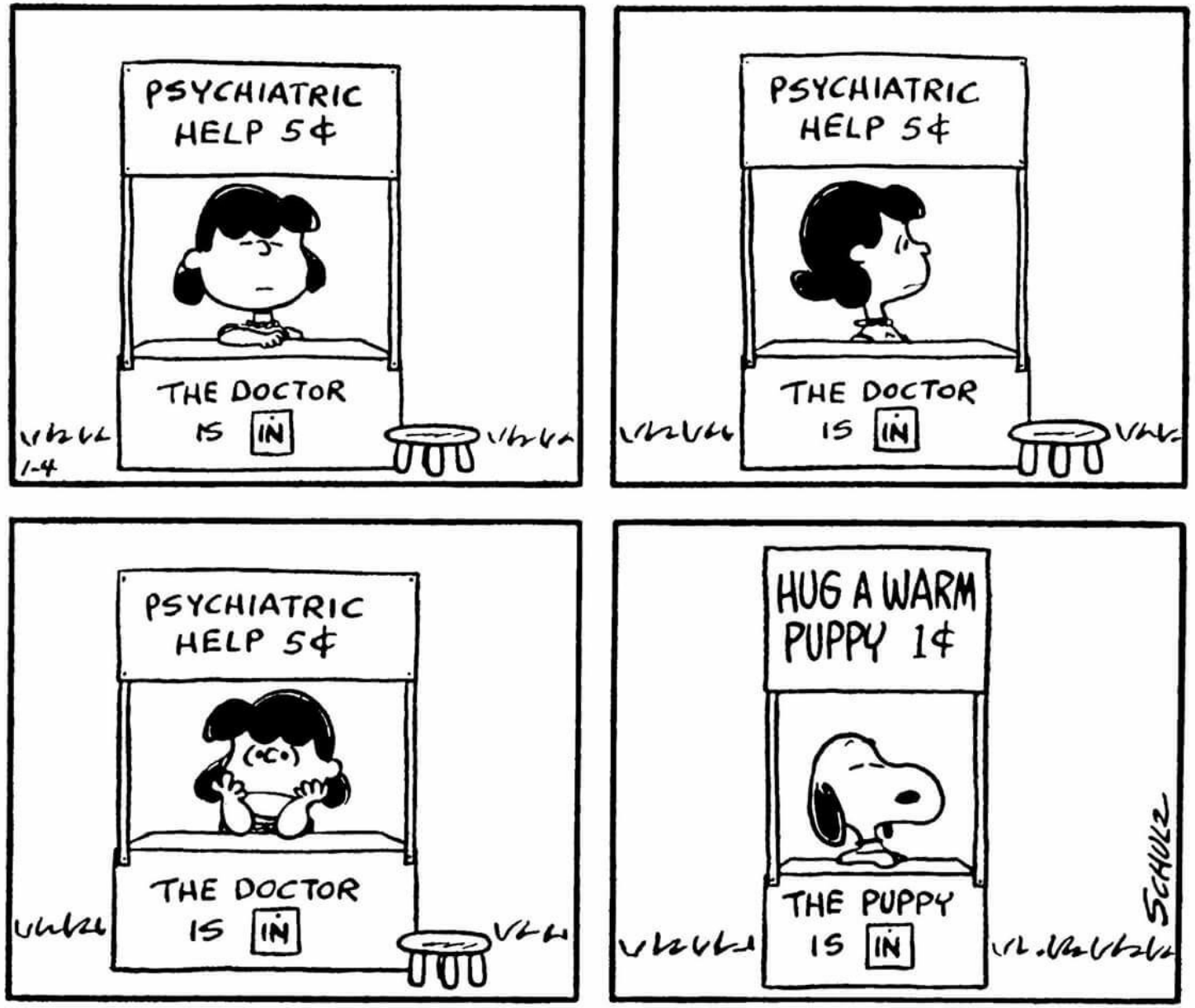
Shifting care from doctor-centred to patient-centred



The new care paradigm aims to help patients get activated.
Doctors become coaches to re-impower and rehabilitate.

It may seem counter-intuitive, but in chronic pain care we need to:

- acknowledge the limitations of the passive or bio-medical approach focusing on sensory experience and pain reduction.
- address pain-related thoughts, emotions and behaviours (drivers of neuroplasticity).


PSYCHIATRIC HELP 5¢
THE DOCTOR IS IN
1-4
PSYCHIATRIC HELP 5¢
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PSYCHIATRIC HELP 5¢
THE DOCTOR IS IN
HUG A WARM PUPPY 1¢
THE PUPPY IS IN
SCHULZ

A Biopsychosocial approach to chronic pain

The key content was published in 2018 at https://www.nps.org.au/australian-prescriber/articles/prescribing-wellness-comprehensive-pain-management-outside-specialist-services

Active self-management:

- Assessment and measurement
- Neuro-education
- Diet
- Social activation: Family and work
- Physical activation: Goals & Activity pacing
- Sleep
- Cognitions, Beliefs & Mood

Analgesics

- Deprescribing, opioids and harm minimisation

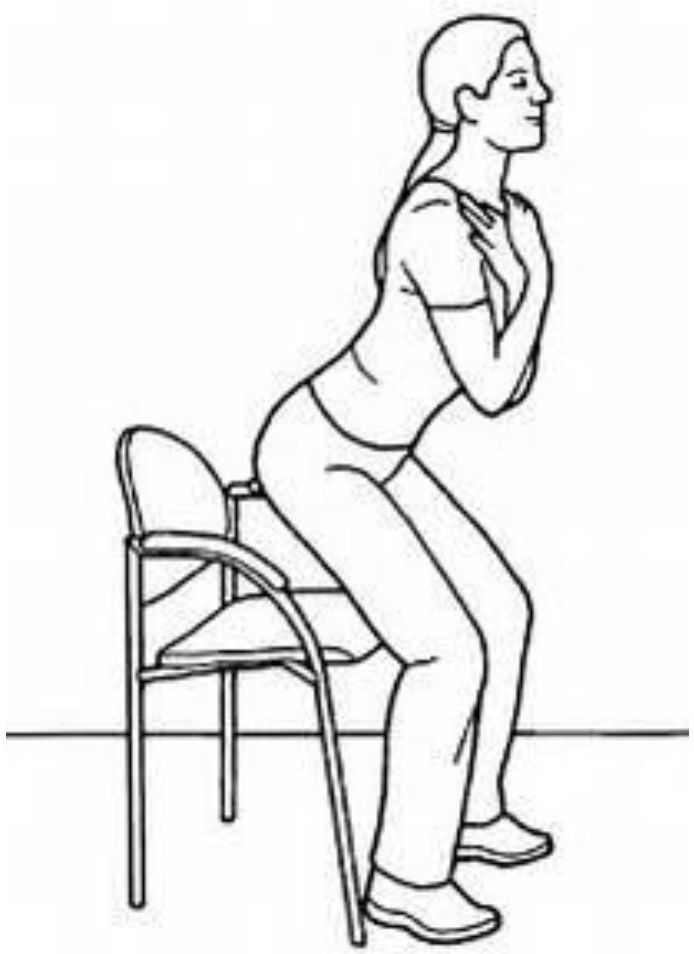
Assessment and Measurement

Functional Assessment

Deconditioning due to inactivity:

The Five Times Sit to Stand Test.

This should take less than 15 seconds.



Outcomes assessments: P.E.G.

Need to measure initially & measure regularly otherwise, care providers, including yourself, cannot monitor outcomes.

1. What number best describes your pain on average in the past week:

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

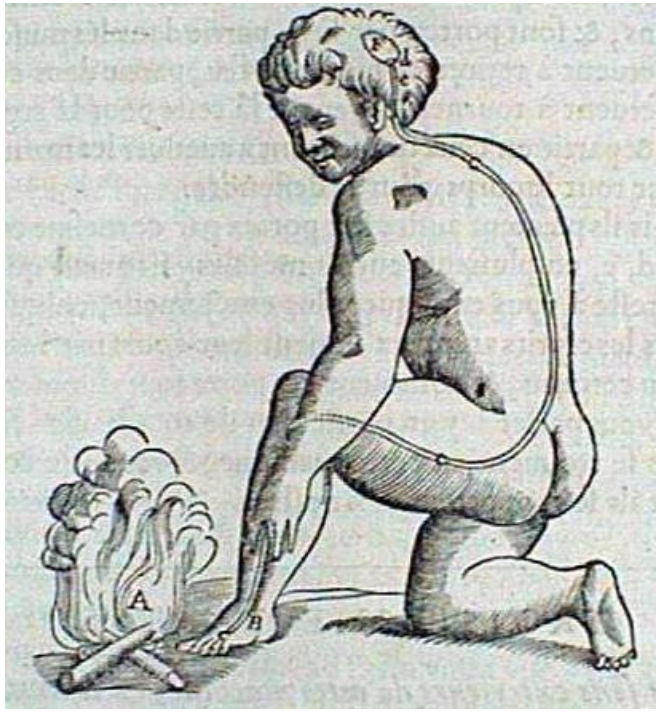
0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

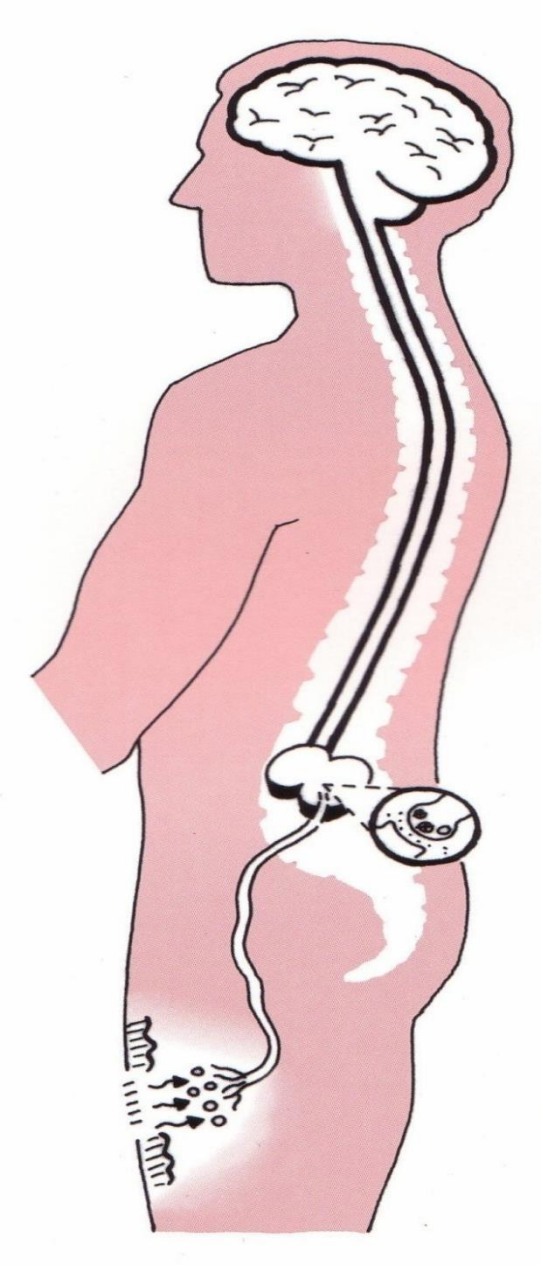
0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Krebs 2009 J of Gen Int Med

Neuro-education



Contributors to pain



Sensitisation (neuroplastic or nociplastic)

Nerve injury (neuropathic)

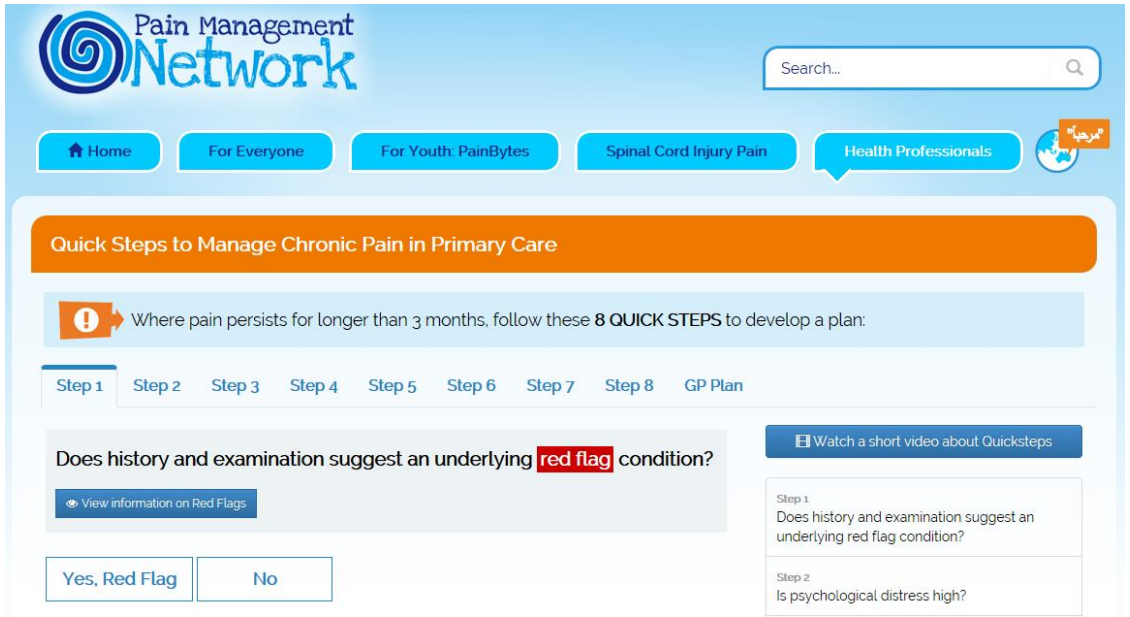
Tissue injury (nociceptive)

Kosek PAIN 2016 Do we need a third mechanistic descriptor for chronic pain states?

Patient education

Hunter Integrated Pain Service (HIPS) series:

- Understanding pain and what to do about it
- Brainman chooses
- Brainman stops his opioids



The NSW Agency for Clinical Innovation chronic pain website https://aci.health.nsw.gov.au/resources/pain-management includes draft care plans for chronic pain

Diet

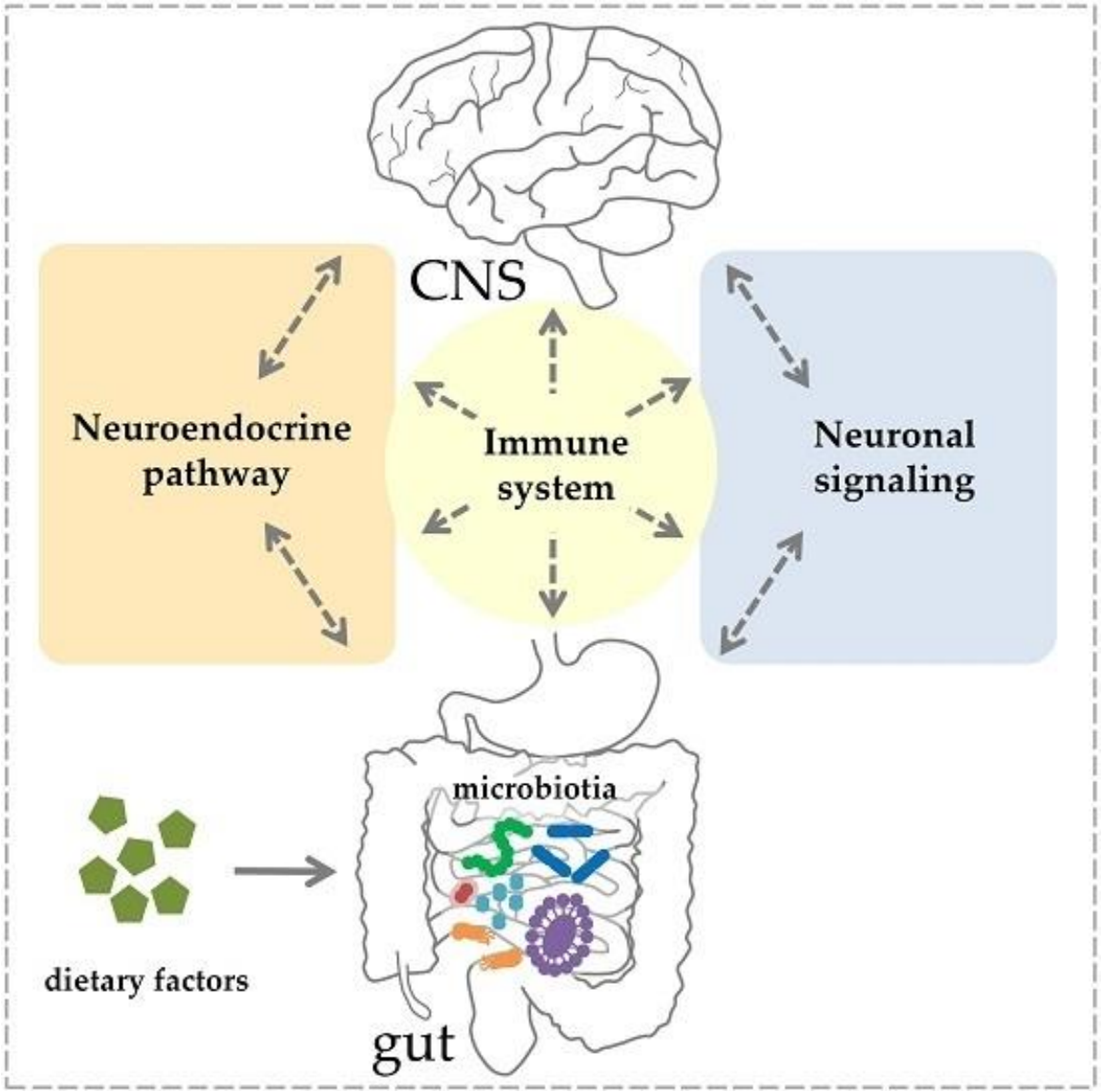
Nutrition and eating

Recommend five serves of vegetables & two of fruit. Avoid processed foods & sugar sweetened drinks.

Obesity independent mechanisms: Western-style nutrition makes an “inflammatory diet.”

This changes the composition & function of the gut microbiota.

The gut–CNS-axis modulates metabolism, autoimmune responses, CNS homeostasis and inflammation (Fleck 2017).



Fleck 2017 Int J of Molecular Sciences

Social activation:
participating with family & work

Social activation: Re-integration

Quality pain care involves encouraging social re-engagement: in intimacy, family or at work.

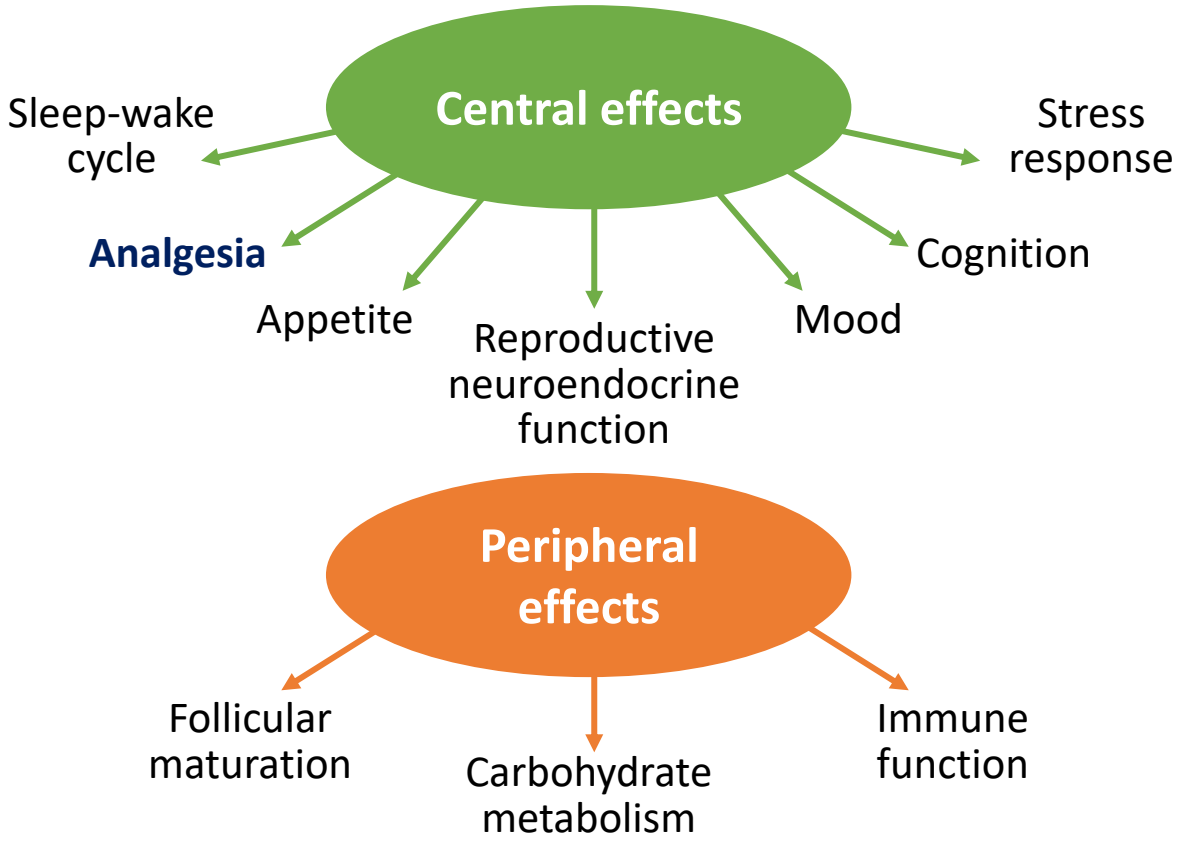
The endogenous opioid system

Modulates social bonding, mood, stress and pain.

Controls social reward and social pain.

Engages with the dopamine (reward) system to calculate which behaviours are unconsciously promoted.

Pharmaceutical opioids may “hijack” these functions.



Adapted from Eyvazzadeh et al. Fertil Steril 2009; 92: 1- 12.

Theories of pain physiology

Theorists describe pain as reflecting a multisensory system of **danger-detection** to the individual (and to the tribe).

Flipping this over: love can be sacrificial.

Physical activation: goals & activity pacing

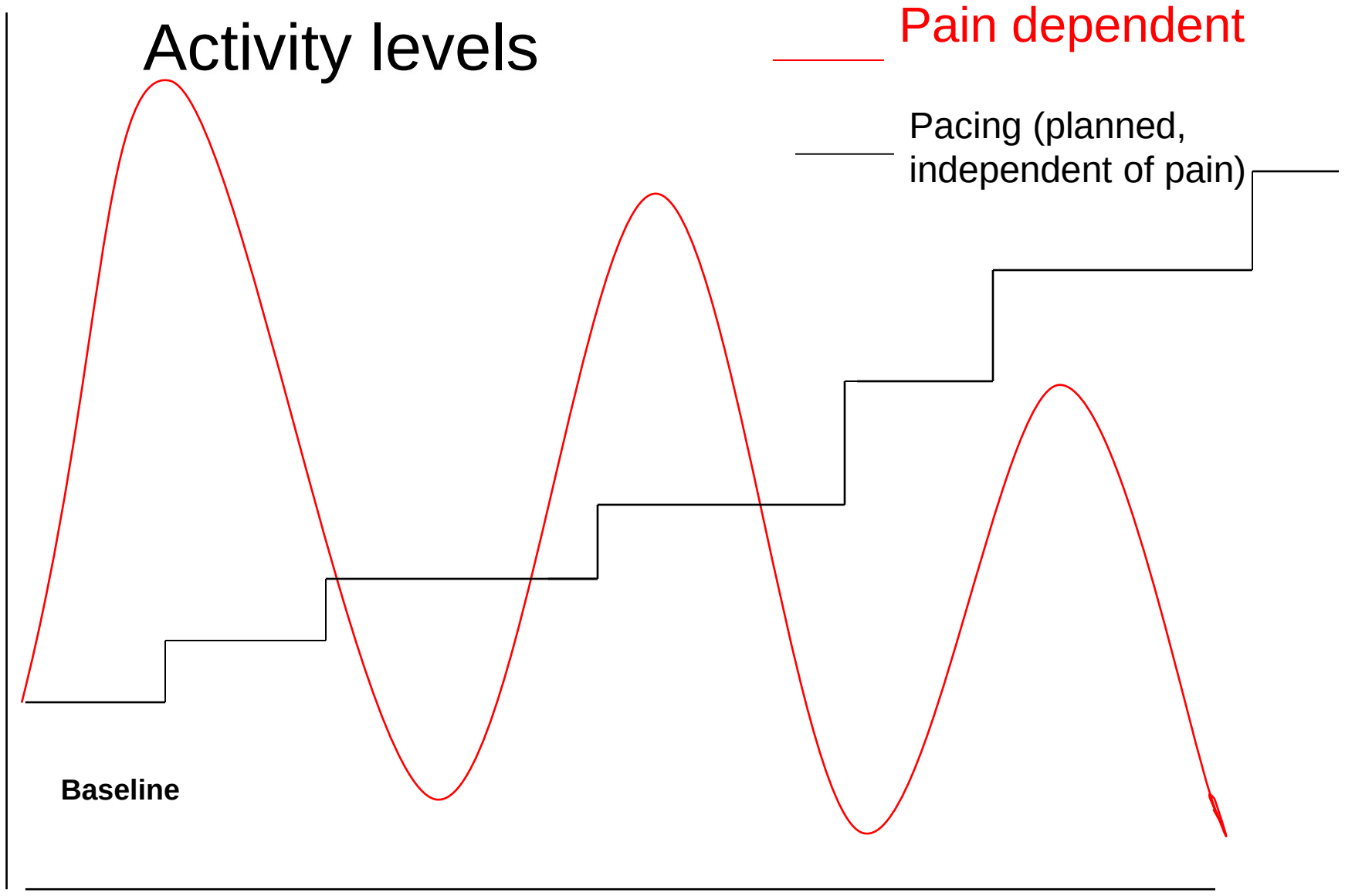
Planning Goals

“Unpack” goals into achievable, concrete and measurable sub-goals.
Identify obstacles & how to negotiate them.
Review goals frequently and document progress.

Activity pacing

Avoid under- & over- activity.

The boom/bust trap increases break-through pain and risks use of short-term opioids.



Activity pacing

This involves structured activity with the initial baseline below patient's capacity to aid confidence building.

Small, meaningful upgrades are set utilising objective outcomes:

- duration of exercise
- duration of rest*
- distance /step counts

Swapping tasks

* Mitchell "Trials" 2016

Cognitive aspects of re-engagement in physical activity

Redirect thoughts:

- "What can I do despite the pain?" rather than "What can I do to get rid of the pain?”
- increases in pain is normal with activity: “I’m sore but safe.”

Deal with movement and activity related fear

Evidence supports our preferencing physical therapists with CBT training.

TIME EFFICIENT MANAGEMENT OF PAIN IN THE OFFICE

A Biopsychosocial approach to chronic pain

The key content was published in 2018 at https://www.nps.org.au/australian-prescriber/articles/prescribing-wellness-comprehensive-pain-management-outside-specialist-services

Active self-management:

- Assessment and measurement
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- Social activation: Family and work
- Physical activation: Goals & Activity pacing
- Sleep
- Cognitions, Beliefs & Mood

Analgesics

- Deprescribing, opioids and harm minimisation

Hypnotics/sedatives

Ineffective: In a prospective Belgian nursing home study, users (Vs nonusers) sleep was worse initially. Over 1 year users sleep relatively worsened again [1]

Unsafe: impair function, learning & cognition

They quadruple opioid overdose rates [2]

Cognitive behavioural therapy for insomnia (CBT-i) is now considered the first line treatment.

[1]Bourgeois 2014 [2]Park 2015

Sleep

CBT-i incorporates 4 elements:

1. relaxation therapy
2. psychoeducation/sleep hygiene
3. stimulus control
4. sleep (or bedtime) restriction strategies.

CBT-I produces reliable, durable benefits in 70% to 80% of patients (Buysse 2017)

Arrange a Sleep Diary

Sleep Diary

SleepFoundation
A OneCare Media Company

Complete in the Morning							
Start date: Day of week:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
What time did you get into bed?	PM AM	PM AM	PM AM	PM AM	PM AM	PM AM	PM AM
What time did you try and go to sleep?	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
How long did it take you to fall asleep?	HRS. MINS.	HRS. MINS.	HRS. MINS.	HRS. MINS.	HRS. MINS.	HRS. MINS.	HRS. MINS.
What time did you wake up this morning?	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
How many times did you wake up during the night?							
No. of times							
No. of minutes							
Last night I slept a total of:	HRS. MINS.	HRS. MINS.	HRS. MINS.	HRS. MINS.	HRS. MINS.	HRS. MINS.	HRS. MINS.
How would you rate your sleep quality?							
Very Poor Poor Fair Good Very Good	○ ○ ○ ○ ○	○ ○ ○ ○ ○	○ ○ ○ ○ ○	○ ○ ○ ○ ○	○ ○ ○ ○ ○	○ ○ ○ ○ ○	○ ○ ○ ○ ○
Was your sleep disturbed by any factors? If so, list them here (ex. allergies, noise, pets, discomfort/pain, etc.)							
Any other comments about your sleep worth noting?							

Complete in the Evening							
Day of week:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
I consumed caffeinated drinks in the: (M)orning, (A)fternoon, (E)vening, (N/A)							
M / A / E / NA							
How many?							
How much exercise did you get today?							
No. of minutes							
Time of day (morning, afternoon, evening, night)							
Did you take a nap? (circle one)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
If Yes, for how long?							
List all Medications you took today							
Approximately 2-3 hours before going to bed, I consumed:							
Alcohol A heavy meal Caffeine Not applicable	○ ○ ○ ○	○ ○ ○ ○	○ ○ ○ ○	○ ○ ○ ○	○ ○ ○ ○	○ ○ ○ ○	○ ○ ○ ○
In the hour before going to sleep, my bedtime routine included: List activities including reading a book, using electronics, taking a bath, doing relaxation exercises, etc.							

Sleep (or bedtime) restriction strategies

This is a behavioural therapy to curtail the time in bed to the actual amount of sleep being achieved.

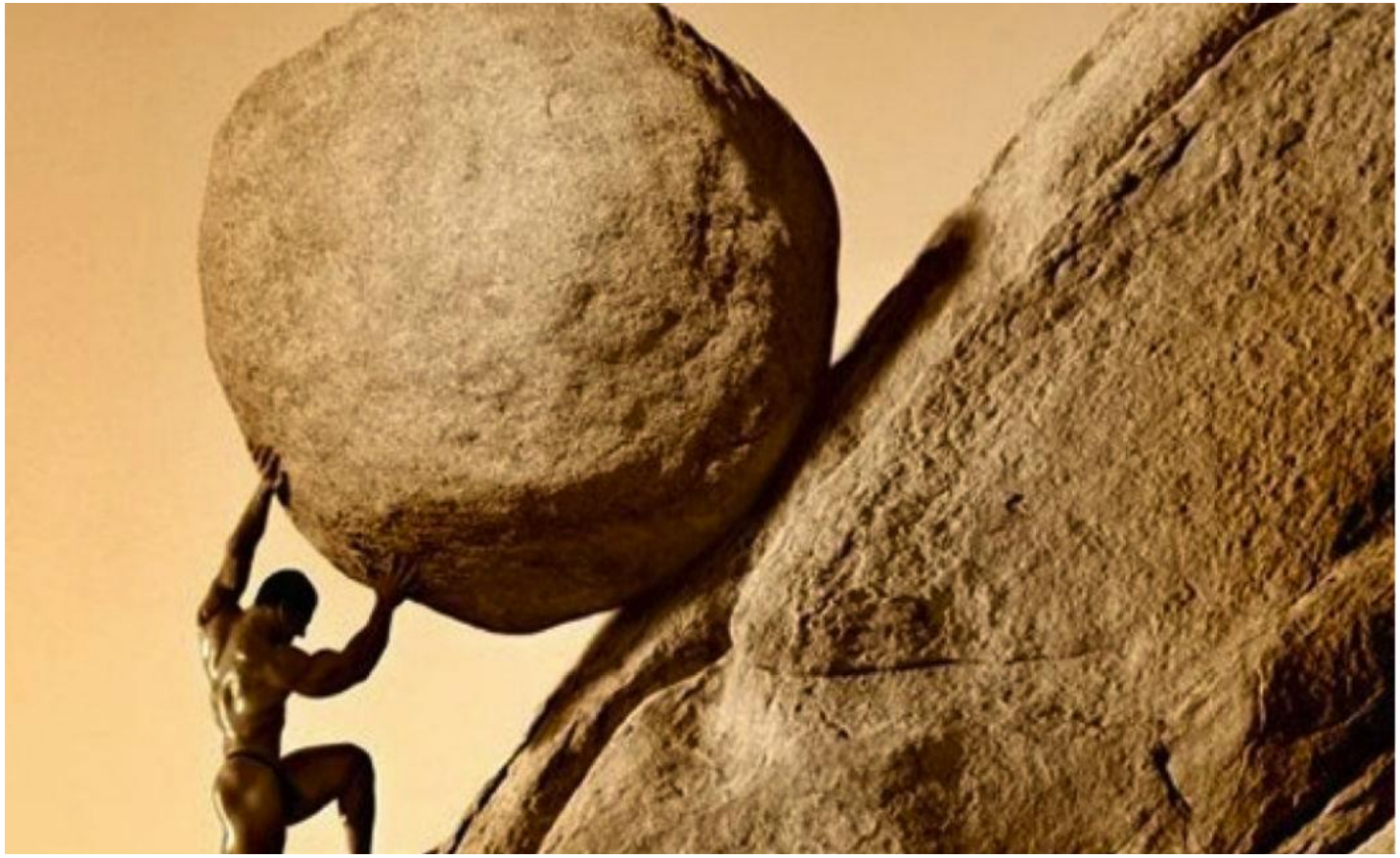
Use a sleep diary to estimate sleep time; with recordings before bed & on awakening; before starting and during weekly follow-ups.

Until an optimal sleep duration is reached, time in bed is either:

- increased by 15–30 min when sleeping > 85% time
- kept stable, or
- decreased by 15–30 min when sleeping < 80% time

It may take 3-4 weeks to become effective.

Adjuncts to benzo deprescribing



Negotiation of weaning rate

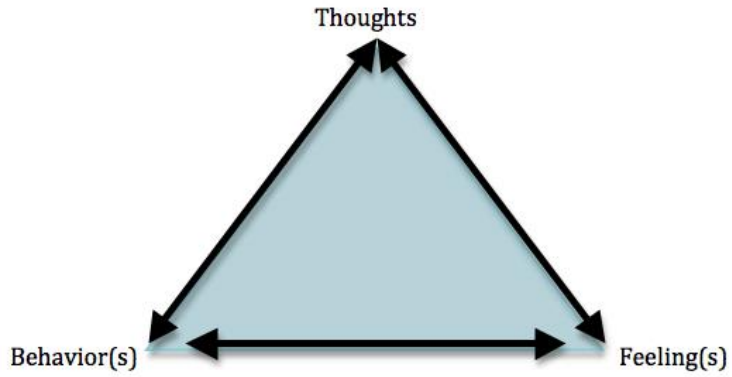
Medication substitution (30 drugs or drug classes described)

Rotation to diazepam equivalents

CBT-i or apps

NB Abrupt cessation from high dose may cause a seizure

Cognitions and emotions



Beliefs

Self-monitor and regulate unhelpful thinking:

- Catastrophising
- Fear avoidance

Encourage:

- Self-compassion
- Self-efficacy

Mood

Depression

Bi-causal relationship with pain

Non-pharma therapy includes:

- scheduling pleasurable activities
- exercise
- healthy nutrition

Active relaxation

Observation of the breath

There are many techniques of mindful self-calming.

Desensitisation = Practicing self-exposure to symptoms without judgement

- Education that pain ≠ damage: pain is activity in the nerves
- Acceptance, keeping moving will reduce distress
- This calms and retrains the brain to process signals differently.

Deprescribing, opioids and harm minimisation

BMJ

BMJ 2013;346:f2690 doi: 10.1136/bmj.f2690 (Published 3 May 2013)

ANALYSIS

Expect analgesic failure; pursue analgesic success

Most analgesic drugs work well but in only a small percentage of people. **Andrew Moore and colleagues** argue that we need to move away from a focus on average response and seek out what works for each patient

Andrew Moore *professor*[1], Sheena Derry *senior research officer*[1], Christopher Eccleston *professor*[2], Eija Kalso *professor*[3]

"For all drugs and in all conditions, fewer than half of patients achieved at least a 50% reduction in pain intensity."

Reducing polypharmacy may improve function.

Medication strategy for opioids in chronic pain

Stop starting them

- Initial prescription <1 week or double risk of use at one year (6% to 13% [1])
- Exclude suicidality
- Bystander naloxone
- Start opioid tapering or cessation whilst implementing multi-modal care.

[1] Shah MMWR 2017

Opioid Agonist Therapy (OAT)

With the aim to minimize harms, OAT involves therapeutic boundaries titrated to progress; with provision potentially varying from repressive to liberal.

As in chronic pain care, patients present on high doses of opioids and treatment aim is to improve function. Unlike pain care, higher doses and lengthier treatment programmes improve outcomes.

Very few patients on long-term opioid analgesics need formal OAT. They all need, however, titration of some OAT strategies.

A new option, depot buprenorphine, may transform any moral arm-wrestle between analgesic provision & addiction.

OAT strategies:

. a single prescriber
. a single pharmacy
. no early prescriptions
. no replacement of lost medications
. daily dispensing
. supervised doses
. inspection of potential injecting sites
. urine drug testing
. Tapering or ceasing is risky

Conclusion

We harm our patients if we assume that pain care is all about opioids & that opioid provision is all about excluding addiction.

For hope and recovery:

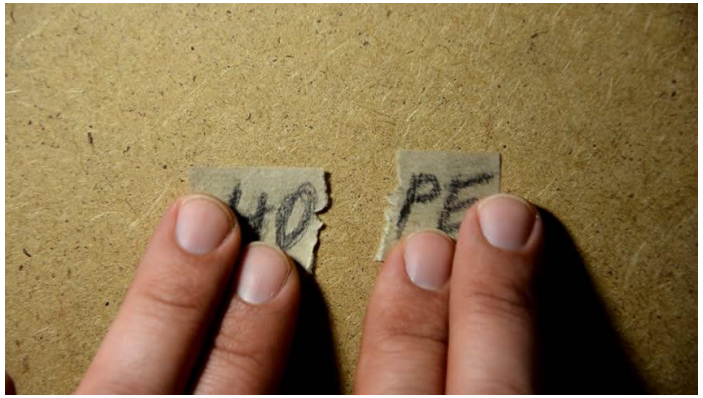
. Assess/measure (FTSST, PEG)

. Informational support: education

. Motivational support: coaching towards multi-modal, active self-management of their multiple chronic morbidities.

For ongoing opioids: aim to minimise harms with methadone-programme-like dependency care.

For ongoing benzos: educate, psychotherapies e.g. CBT-i, and wean.



Q & A

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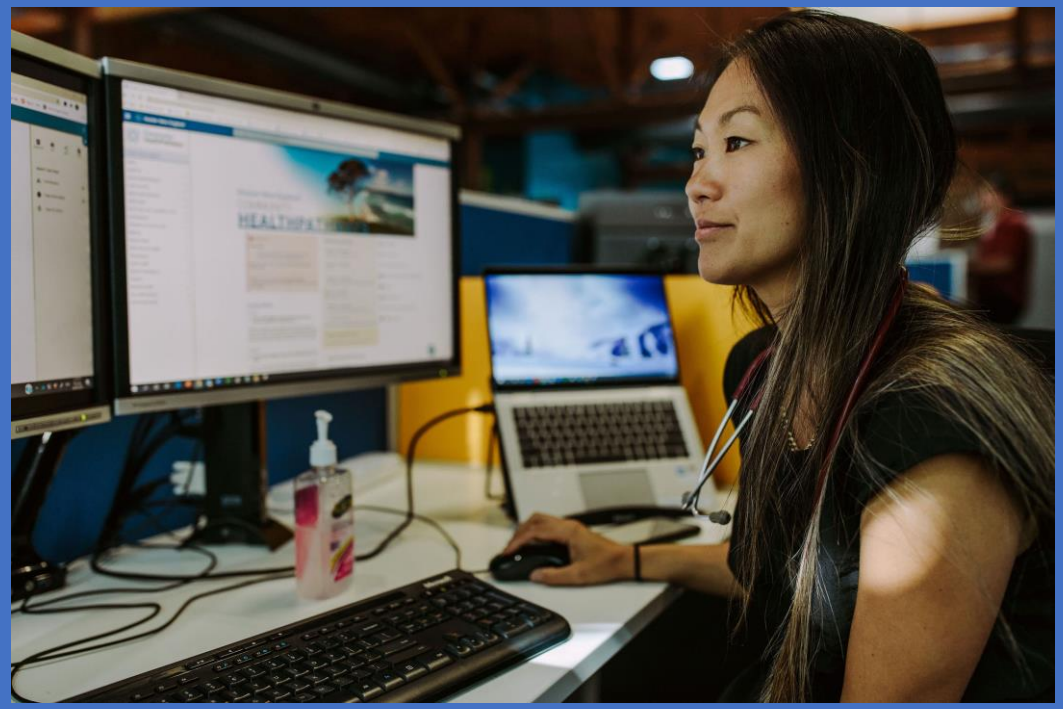

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