PAIN OR ADDICTION – WHAT IS IT?

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My Background

- Hospital trained at Waikato
- RGON
- Nurse for 40 years, AOD field – 20 years (Australia & NZ)
- B.HSc. (Nursing) 1994 UWS
- B.A.(Psychol) 1998 Macquaire Uni, Sydney
- P.G.Cert. H.Sc. (Addiction & Coexist. MH) - Otago
- P.G.Dip.H.Sc.(Mental Health Nursing) - UoA
- Master of Nursing –UoA
- Endorsed as NP April 2012
- NP role January 2013

Joint initiative – CADS /Pain team

- Extension of Alcohol and Other Drug Consult Liaison
- Started in about 2009
- GP referrals ‘bouncing’ between services
- Ours? Yours? Decision? - what needs to be excluded?
- Attend weekly/ fortnight Pain MDT meetings
- Acute (inpatient) Pain team plus Chronic (outpatient) Pain
- Team (Pain Specialists, Psychologists, Physio, nurses, NP, MH CL Psychiatrist)
- Joint assessments
- Ruling in / ruling out / differential diagnosis

Process

- Discuss referrals in common – from either team
- Access to the electronic records – review the history
- Patient is known to who?
- Mental health / Addiction / Medical Hx
- Surgical interventions?
- Previous investigations?
- ED presentations?
- Current medications
- Impression - Pain / Addiction / Both / Neither ?

Benefits – unpacking comorbidity

EXCLUDE PHYSICAL COMORBIDITY:

Pain team – further investigations (MRI etc), liaise /consult / refer - other medical teams (ortho, neuro, surg, gynae etc)

Does the pain condition warrant treatment with opioids?

Reduction regime, tight dispensing; non opioid pain management (gabapentin, Venlafaxine etc) plus physio and psychology, back to Primary Care (GP/NP).

Failure -> back to CADS

Benefits

EXCLUDE MENTAL HEALTH & ADDICTION

- New patient? Known to CADS?
- Mental Health Hx
- Addiction Hx
- Opioid Substitution Treatment (OST) patient Methadone / Buprenorphine (Suboxone) – current or past ?
- Looking for an alternative legitimate source of opioids?
- OST – aging cohort; physical health problems (infection, emboli, cardiac, COPD, Hep C, old injuries); increased rate of hospital admissions

Case study 1 – “Will”

- 40 plus NZ European male
- Registered Health Professional
- First referred by Pain team following acute admission – post operatively -> AOD Consult Liaison
- Poor analgesic control
- PHx Oxycodone 720 mg daily x 15 years
- “Restless leg syndrome”
- CADS f/u – Comp. asessment – Opioid dependence – recommended OST.
- Declined CADS input (OST or Relapse Prevention).
- Back to referrer / Reminded of responsibility re Professional issues

“Will”

- Patient driven rapid opioid reduction
- Continued to work
- Six months opioid abstinence ……..
- Diverted / Relapsed / Discovered / Terminated / Reported
- Self referred to CADS; wanting OST
- Costs – marriage, family, job, registration, finances
- Stabilised quickly on Suboxone 12 mg OD
- Relapse Prevention Group for Professionals - CBT / Psychodynamic / Family systems
- Working with professional body - RTW

Case study 2 – “Greg”

- 65 plus NZ European male
- On methadone about 40 years
- GP prescribed - ?Pain ?Addiction
- Nil IDU for 40 years
- 95 mg daily, 6 takeaways a week
- Various GPs inherited him – nervous about longstanding opioids – referred to CADS /Pain clinic multiple times
- Finally seen joint assessment (CADS/Pain)
- Pain team - No role for opioids!
- Offered physio, psychology, other meds – non compliant
- GP started opioid reduction

“Greg”

- Reduced to 75 mg
- Not happy! – self referred to CADS wanting OST
- Commenced on Opioid Substitution Treatment (Methadone)
- Patient happy – can remain on a stable dose
- GP happy – no longer prescribing outside his brief

Case study 3 - Raewyn

- 35 year old NZ European female
- PC – “addicted to Codeine”; initially prescribed for pain but now to lift mood
- Prescribed 330 mg daily, dispensed 77 tablets weekly
- Gets ahead, runs out, experiences opioid withdrawal symptoms, purchases OTC codeine preparations
- First use – 16 y.o.a for period pain; increased use 6 years ago with family breakup and disc bulge (Nurofen plus 30 tabs daily)
- 2017 – Became scared and tired - Accessing Codeine now main focus – $10K debt, mostly for codeine

“Raewyn”

- No injecting or illicit opioid drug use history ever
- Hx of heavy alcohol use and ongoing cannabis use
- PMHx – discectomy 2017; previously prescribed gabapentin but preferred codeine ; Zopiclone 15 mg po nocte (long standing); Sertraline in the past but poor compliance
- Other relevant – Poor upbringing – parental MH&A issues; sexual abuse - ACC Counselling; single mother - works part time
- Dx: Opioid dependence
- Tx: OST – Suboxone; Case management, Group therapy, slow reduction off Zopiclone
- 1 year later – stable, motivated, gaining insight

Summary

- Collaborative approach / building relationships/ breaking down barriers
- Clarifying the clinical picture
- Timely assessment and treatment vs. falling through the gaps
- GP not left ‘carrying the can’
- Learning all round
- Patient able to stabilize and get their life back

Questions?