

Commentary

Reducing the risk of opioid misuse in persistent pain: Commentary on Jamison et al.

Jamison et al. [6] describes in this issue a pilot study, the first of its kind, of psychological intervention to improve the adherence to opioid therapy in chronic pain patients at a high risk of misuse. This is an excellent initiative, a welcome alternative to using screening measures to refuse providing pain patients an adequate trial of opioids. Subjects had chronic back or neck pain, and were maintained on opioids after many unsuccessful treatment attempts. Jamison et al. opted to try to achieve the best pain management with the existing dose of opioids.

Patients were assessed for the risk of misuse with a combination of self-report, physician judgement, and urine screening. High-risk patients were randomised to a psychological intervention to improve compliance or to a no-intervention control; the low risk group constituted a comparison. The intervention involved group education and worksheets on opioid risk, and individual motivational counselling, all aimed to change patterns of misuse. Patients monitored their own compliance, backed by monthly urine screens. Opioid prescription was conditional on task completion.

The results are encouraging. The intervention group became low risk – comparable to the low risk comparison group – while the high risk controls were unchanged. The psychological intervention was acceptable and the dropout was low, both important findings considering that patients are often characterised as unwilling to change their pattern or the extent of opioid use.

We have some reservations about the study design and conduct that affect interpretation. First, the patients took different doses of different opioids at the outset, doses that were assumed to maximize analgesia and function while minimizing the adverse effects. Yet pain control seemed less than satisfactory at the baseline: a mean of 6/10. Perhaps patients had developed tolerance. Also, the widespread use of immediate-release opioids is surprising in high-risk patients, and a suitable target for change. Second, change scores would have given a more clinically useful account than the group means [9].

Psychology is central to the intervention: changing beliefs and behaviour by a mixture of self-monitoring, education and group discussion of alternative solutions to the problems for which patients overuse opioids. Although the authors are properly cautious about reporting the significant decreases in the pain intensity and anxiety in the intervention group, since they were not targets of treatment, these changes are potentially important and worth assessing more closely in the future studies. So a third concern is that if a salient reason for opioid misuse is self-medication for anxiety and depression, as the authors propose, then psychological interventions that target those conditions directly is preferable to

using opioids [10]. The trial also reveals that craving plays a surprisingly strong part in continued opioid use and, presumably, overuse.

These findings all highlight how little we understand the patients' relationships with their medications. Clinically, many report little or no effect of opioids on pain or its impact but are alarmed at the suggestion that the opioids might be withdrawn. Patients may be describing cognitive/emotional effects, such as dulling and unhappy rumination about pain problems: we urgently need more psychological research in this area [8]. Unfortunately, it is common for psychologically-based pain management services to exclude patients who use opioids or to exclude analgesic use from the targets for change [4].

One of the study's strengths is its attention to the needs of patients commonly rejected at the onset or during delivery of the services. Risk assessment tools are improving but remain unsatisfactory [11], so using them to refuse patients will deny treatment to some who would use opioids appropriately. But might these patients have done as well without opioids, but with a more extensive psychological intervention?

From a broader perspective, one viewpoint on prescribing starts from an individual's right to try opioid treatment and a willingness to prioritize the patient's wishes or demands. The opposing viewpoint is based on the difficult consequences, for the patient and for society, of liberal opioid prescription in the light of weak evidence of efficacy in musculoskeletal pain [7], except for osteoarthritis [1]. Can opioid treatment be appropriate as the last step when it may decrease the quality of life through adverse effects, and without significant pain relief [5]; and when the decision may be hard to reverse in high-risk patients? There are ethical issues both about refusing opioids when risks are high, and about exposing patients to the risks with a low likelihood of benefit (see an excellent recent review by Ballantyne and Fleisher [2]).

Jamison et al. describes US pain clinics as 'overwhelmed' by patients using opioids unwisely, and requiring action to improve the situation. Why is the problem of opioid misuse so prominent in the USA compared to Northern Europe? Can differences in health care systems, prescribing practices, and patient expectations account for differences in the rates of opioid misuse in pain? Does direct marketing of drugs to the public strengthen the belief that there is 'a pill for every ill', and that other approaches are unnecessary? The commercial priorities of pharmaceutical companies inevitably influence representations of health problems and solutions, and emphasise potential benefits rather than the risks. Additionally, in their wish to help desperate patients, prescribers may go beyond the evidence. Perhaps, also, some of the practices

of cancer pain management with opioids have been uncritically translated into the treatment of non-cancer pain.

The goals of pain treatment are to provide pain relief and to improve function. Those goals will be met in some patients by prescribing opioids, and in others by withdrawing them in favour of alternative treatments. The recently updated UK guidelines [3] on opioid prescribing for chronic pain recommend discussing with the patient the potential problems of long term opioid use, with ongoing assessment of risks, regular review, and sharing of information and concerns with others involved in the patient's care. These practices are by no means novel or unique, but this is an area where openness about evidence of efficacy balanced against risks is particularly important. Effective opioid prescribing is undermined on the one hand by pressures to overprescribe and on the other by overestimation of risks; developing ways to reduce the risk, as shown by Jamison et al., helps us to prescribe effectively.

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