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Managing Chronic Pain in High- Risk Patients

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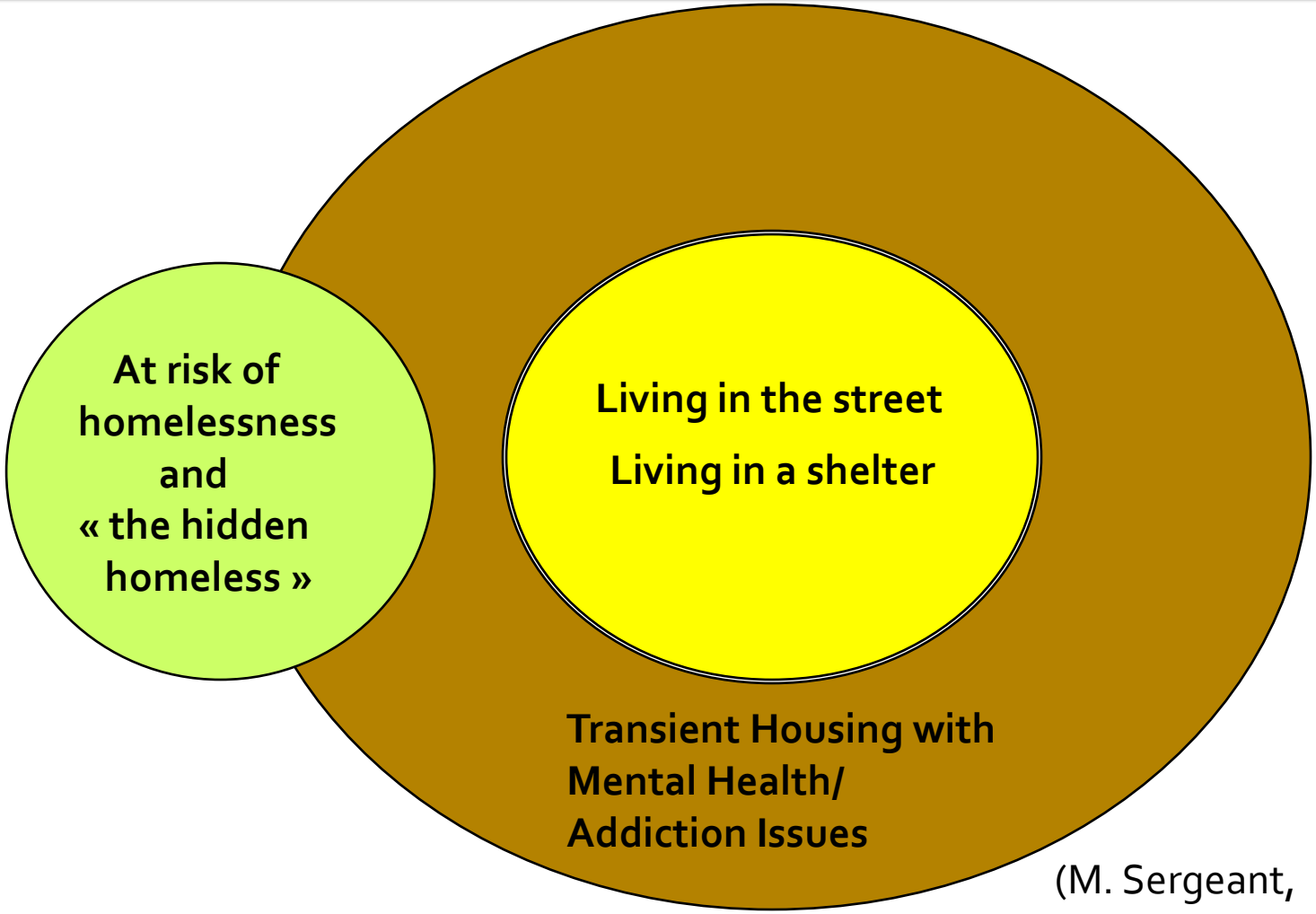
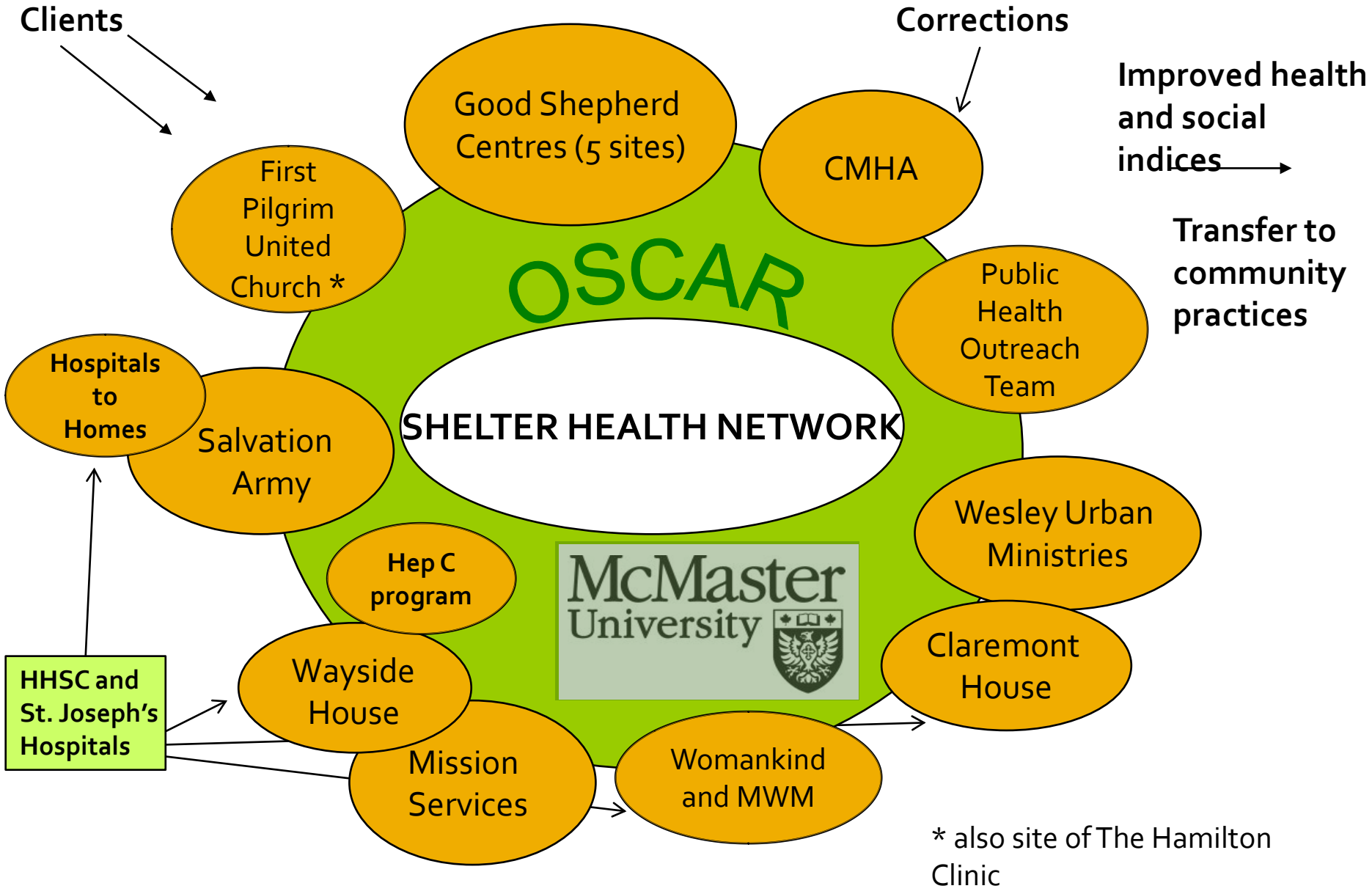
« High Risk patients»

- The Hamilton Shelter Health Network
- The Hamilton Clinic (MMT)

Shelter Health Network



(M. Sergeant,
Shelter Health Network, 2007)


Clients
Corrections
Improved health and social indices
Transfer to community practices
Good Shepherd Centres (5 sites)
CMHA
First Pilgrim United Church *
OSCAR
Public Health Outreach Team
Hospitals to Homes
Salvation Army
SHELTER HEALTH NETWORK
Wesley Urban Ministries
Hep C program
McMaster University
Claremont House
HHSC and St. Joseph's Hospitals
Wayside House
Mission Services
Womankind and MWM
* also site of The Hamilton Clinic

Objectives:

- Challenges and barriers in the population
- Typical "inner city" pain cases
- The Hamilton Shelter Health Network and The Hamilton Clinic – some background
- Building capacity

Challenges

- Poverty and homelessness
- Disability
- Addiction
- Mental Illness and trauma/abuse

Challenging Cases

1. The patient with pain has a mental health diagnosis
2. The patient with pain is currently misusing opiates or other substances
3. The patient with pain is already on methadone or a structured opioid therapy protocol
4. Pseudoaddiction – referrals to MMT

DSM-IV Criteria for Substance Dependence

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by ≥3 of the following, occurring any time in the same 12-month period:

- **1. Tolerance**
- **2. Withdrawal**
- **3. More or longer** use than intended
- 4. Persistent desire or **unsuccessful efforts to cut down** or control
- substance use
- 5. Great deal of **time** spent obtaining, using, or recovering from use
- 6. Social, occupational, or recreational **activities are given up** or
- reduced
- 7. Continued use despite physical or psychological **consequences**

ADDICTION

The Four "C's" of Addiction

- Loss of **C**ontrol
- **C**raving
- Continued use despite **C**onsequences
- Inability to **C**ut down

Shelley, 32 F

- Severe degenerative disease of hip post septic arthritis
- Cut off her prescription opiates by her family physician
- Began using street morphine to control her pain, currently snorting morphine 2-400 mg daily
- Presents requesting methadone maintenance for addiction-meets DSM criteria

Denise 47 yr old F

- MVA with ABI 25 yrs ago
- Past dx of bipolar disorder
- Current hx of intermittent cocaine and opioid misuse
- Severe chronic low back pain, L knee pain due to ligament instability, foot pain d/t calcaneal fractures secondary to a suicide attempt 2 yrs ago (jumped from a bridge onto concrete)

Michael, 34 yr M

- Hx of addiction to opioids and cocaine
- On oxycodone 160 mg BID for R sciatic pain
- Other meds: Amitriptylline 50 mg; Duloxetine 30 mg; Clonazepam 1 mg BID

James, 54 yr M

- Hep C with past hx of IVDU
- Type 2 DM, chronic leg wound
- On high dose methadone 165 mg OD (as MMT)
- On Hydromorphone 8 x 24 mg daily from FD

Dianne 46 yr F

- Looks after 2 grandchildren most days
- Chronic low back pain
- Hep C positive with past hx of drug abuse now remitted
- EtOH – drinks about 4-6 beer daily
- Taking 9 codeine 30 mg daily for pain – stable dose for 2 years
- Becomes irritable with staff when prescription not timely or properly filled

Barriers to Better Pain Care

- Waitlists for chronic pain referrals are long – patients with addiction histories are at increased risk of relapse because pain is a trigger for them to misuse Rx opioids.
- May no-show for complex reasons
- Patients may not disclose all the issues that impact on a pain assessment (e.g. past abuse or trauma)

Management Solutions

- Goals are the same as for pain alone: improved quality of life, function in ADLs, etc.
- Shared Care: Methadone maintenance programs can be an ideal setting for management of methadone treatment for pain in high-risk patients with close collaboration between teams

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