Safe and effective use of opioids for co-occurring disorders

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Co-occurring disorders and clinical care for complex illnesses- safe and effective use of opioids may be only one of the areas where we need collaboration. Norm Buckley from the Michael G. DeGroote Institute for Pain Research & Care explains

The Michael G. DeGroote Institute for Pain Research and Care focuses on pain research and care. We recognize that to understand pain in all its complexities and provide care, it is necessary to conduct research from multiple disciplinary perspectives. It is widely accepted that the best care for chronic pain involves an interdisciplinary approach, and thus, the best research should do the same.

In a previous article for Open Access Government, we reflected on the need for a clinical trials network that could carry out the sorts of trials necessary to inform the care of patients with complex multifactorial conditions- co- occurring disorders. Caring for patients with a single diagnosis with clearly established best practice strategies can be challenging, but the path to treatment and recovery is most often well laid out. On the other hand, for the patient experiencing multiple conditions simultaneously, it may be difficult to select the best care.

In this article, we will suggest some elements of a strategy towards establishing optimal care for complex disorders and identify some of the perhaps unexpected allies who are recognizing the value of collaborating towards solutions for these complex problems. It is comforting to know that there are many fora where this collaboration may occur.

The ‘coal face’ or leading edge of care is primary care, but the specialties of pain, substance use, and mental health are areas where collaborations have been conducted in the past and show promise going forward. Efforts must also be made around reconciling guidelines for the care of different conditions. A colleague recently pointed out that for the primary care physician, reviewing guidelines for all the conditions they may face in a single day of practice could occupy their entire workday. (1)

Guidelines for multiple Conditions

First, the issue of guidelines for multiple conditions. Treatment strategies for one condition may have guidelines whose recommendations conflict with those for a second condition. Medications may have interactions that complicate concurrent use. Specialties focus their efforts on the illnesses that fall within their area of expertise and make recommendations in those areas.

As we discovered with the 2017 Canadian Opioid Guideline, often the information required to resolve these conflicts is not available, and a practitioner must develop a care plan empirically – 'one case at a time'. This is challenging for the practitioner, and the expected course of response to treatment may not be known. Dr Andrea Darzi, in an e-book created for Open Access Government (February 28, 2025), describes a process for resolving conflicts amongst multiple guidelines that make disparate recommendations on a topic such as the use of opioids for chronic pain, or cannabis for pain. This process, Recommendation Mapping or RecMap, could also be expanded to identify areas where guidelines for different conditions present a practitioner with treatment plans that may conflict. This is a large project and could be undertaken using artificial intelligence techniques, as suggested by my colleague, Dr. Arun Radhakrishnan.

Towards collaboration across Specialties

Now to collaborators. The path forward will, of necessity, require collaboration across specialties, amongst groups focused on care for specific disorders, and across different areas of practice. These complexities place ever greater burdens on the primary care teams that are the first point of contact for patients with these issues. Active collaboration among groups focused on specific issues is essential to provide appropriate guidance and support to patients and their care teams. Happily, some of these collaborations exist, and others are developing to address issues of complexity.

Recently, I attended the annual meeting of the Canadian Centre for Substance Use and Addiction, called 'Issues of Substance'. This meeting was held this year in Halifax, Nova Scotia, Canada, with a large attendance – over 900 people. I am primarily a pain clinician from an anesthesia background. One might wonder what a pain clinician is doing at a meeting that focuses on addiction and its treatments. I have been involved in pain care for over 30 years, and experienced firsthand the drive to avoid 'opiophobia' to offer pain treatments.

Pain was identified as a 'fifth vital sign' that needed to be assessed and treated, but we had a small number of pain-specific pharmacological interventions. This led to the much more liberal use of opioids. The Declaration of Montreal in 2010 led the World Health Organization to recognize that pain care is a basic human right. However, the pharmacological resources for pain treatment were limited, and to some extent, this probably also accelerated the uptake of opioid prescribing.

As opioid use became more widespread and adverse events increased, attention turned to the 'Opioid Crisis'. In Canada, the Canadian Centre on Substance Use and Addiction (CCSA) led a diverse group to develop the 'First Do No Harm' strategy, released in 2013. This document made recommendations that addressed the need for pain care and substance use treatment equally. To some extent, the combined message was lost in the execution of policy, but reappeared, leading to the formation in 2019 of a federal pain task force by the Honorable Ginette Petitpas Taylor, Minister of Health.

The final task force report, ‘An Action Plan for Pain in Canada’, makes recommendations under six summary areas. In these, there are many areas of overlap between pain and substance use – origins, the role of trauma, both physical and psychological, and issues related to social determinants of disease. Effectively addressing pain through research and clinical care must include attention to the issues of addiction.

The mental health perspective

Mental health is the third area of comment here. We have seen valuable research documenting the co-occurrence of pain and mental health disorders from Canadians, such as Renee El Gabalawy, identifying the co-occurrence of pain, anxiety, and depression from large-scale community health surveys. [(2)] Anecdotally, clinicians often see co- occurrence of anxiety, depression, and pain and have noted the synergy of these in worsening symptoms of both disorders. Suicide is doubled amongst sufferers of chronic pain compared to the general population.

It was very comforting to hear at the Issues of Substance meeting that active collaborations are being developed in Canada between the CCSA and the Canadian Mental Health Commission (CMHC) to address common issues in substance use and mental health. It was more comforting to hear from these leaders that they, too, recognized the importance of including pain as a partner in these collaborations. In fact, leaders from the CCSA were cognizant of previous collaborations around the First Do No Harm strategy and recognized that, as we independently developed over the past 10 years, this collaboration had been lost.

Closing remarks

As an observation about possibilities, there has been an increasing number of clinical services developing overt programs for treating their initial referring diagnosis, whether it be pain, substance use, or addiction, in concert with co-occurring diagnoses such as mental health conditions, pain, or substance use. These programs, frequently pilots, are identifying some of the areas of challenge but also providing suggestions for ways forward. This is the future of clinical care and research, including the complexity of research to answer questions from real-life experiences of our patients and those addressed by clinicians who care for them.

References

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