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# If not opioids – then what?

Opioid medicines have a limited role in chronic non-cancer pain. An emphasis on active self-management is a better way to improve function and quality of life for people living with chronic pain.

**Every day in Australia:**

- 3 people die from opioids[1]
- Nearly 150 people are hospitalised and 14 people present to emergency departments due to opioid-related harm.[1]

## Key points:

- Long term management of chronic non-cancer pain should take a multidisciplinary approach that minimises use of opioid medicines.
- Effective pain management requires a strong, continuous, therapeutic relationship between doctor and patient.
- Active self-management strategies can build patient confidence that chronic non-cancer pain can be managed without an opioid medicine.
- Although chronic pain is a complex and challenging area to manage, GPs and patients should be aware of the effective non-pharmacological therapies available to support them.
- Non-pharmacological therapies can produce improvements in pain and function that are similar to those of opioid medicines, without the harm.

## If not opioids, then what?

Available evidence does little to support the use of opioid medicines for long-term management of chronic non-cancer pain. Clinical guidance currently recommends a multidisciplinary approach with an emphasis on non-pharmacological strategies and active self-management as the preferred method to improve function and quality of life.[2]

But how do GPs motivate their patients to become active participants in their own non-pharmacological pain management plans?

And what are some examples of non-pharmacological therapies that are available for people living with chronic non-cancer pain?

## The limited role of opioids

Current clinical guidelines do not recommend the use of opioids in long-term chronic non-cancer pain management.[3–5]

Available evidence examining long-term (> 1 year) opioid efficacy and risk remains insufficient to determine the effectiveness of this therapy for improving chronic pain and function.[6]

In a recent meta-analysis of 96 RCTs involving over 26,000 patients with chronic non-cancer pain, treatment with opioids did not provide clinically important improvements in pain or function when compared with placebo.[7] Although statistically significant, these improvements were less than the minimally important difference identified for either measure. They reduced pain by −0.69cm on a 10 cm visual analogue pain scale (where a minimally important difference = 1 cm) and improved physical functioning by 2.04 points on the 100 point 36-item Short Form Survey physical component score (where a minimally important difference = 5 points).[7]

Opioids were associated with less pain relief during longer

trials, which may be a result of opioid tolerance or opioid-induced hyperalgesia. The authors suggested that a reduced association with benefit over time might lead to prescription of higher opioid doses and consequent harms.[7]

In contrast, evidence on opioid-related harm continues to expand, with studies suggesting that higher opioid doses are associated with increased risk of harm.[6,8]

The harm associated with long-term opioid therapy is becoming more widely understood and includes; overdose, misuse, falls, fractures, myocardial infarction, endocrine effects, cognitive impairment and gastrointestinal problems.[6,8] Opioid effects on the endocrine system include opioid-induced androgen deficiency (hypogonadism) and associated problems of sexual dysfunction and infertility.[9]

At any stage in the opioid prescribing journey, it's important for prescribers to recognise and discuss with their patients both the limited role of opioid therapy in chronic non-cancer pain, and the potential for serious harm over the long term.[4] These are particularly important topics when starting conversations about reducing or stopping opioids.

***'I hardly ever start patients on opioids now, and if I do, it's only after exhausting other avenues.***

*A saying that has changed my approach to opioid prescribing is, 'You have to have an exit plan before you prescribe.'*

*As an example, I often say, 'Look, I'm starting you on an opioid to give you some temporary relief so we can get you to the physio to set exercise goals and get you back to doing things you enjoy. After a period of time eg, 4–6 weeks we'll slowly taper off the opioid as you'll be able to function better by then.'*

*Dr Andrew Broad, GP*

# From pain cure to pain management

The basis for effective pain management is a strong, continuous therapeutic relationship between doctor and patient.[4] Providing information and reassurance in a supportive environment enables patients to engage in shared decisions about their treatment goals. It should be acknowledged that a trusting, therapeutic relationship takes time and effort to build, and that this can be costly to patients in terms of time, financial burden and emotional effort.

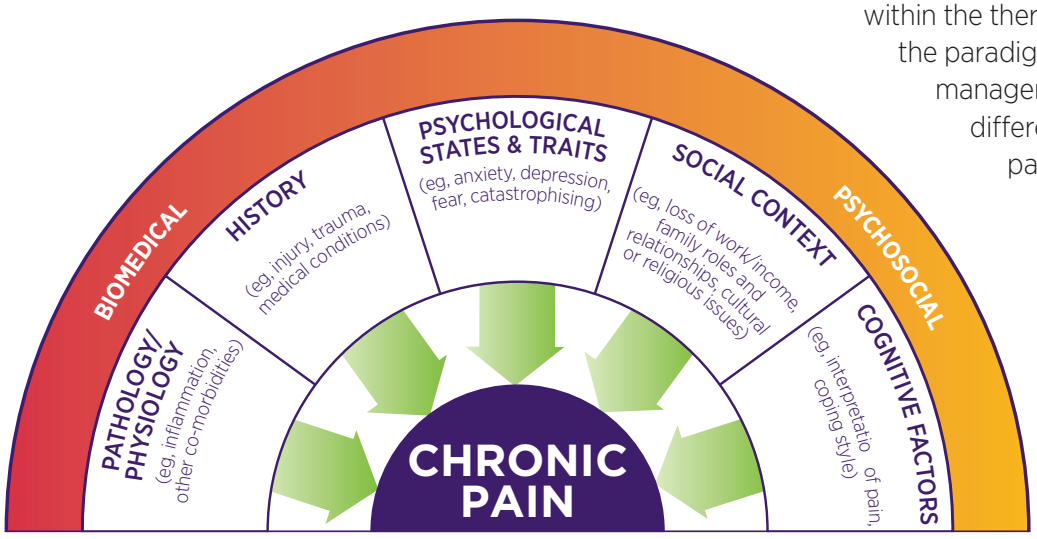
*One of the most powerful motivating factors for patients is the relationship they have with their health care provider. So, before you think about particular strategies that might motivate your patient, think about the therapeutic alliance.*

*How well do you and your patient work together? How much trust does your patient have in you?*

*The interest you show in your patient's health and wellbeing will be an important contributor to their clinical outcomes.*

*A/Professor Toby Newton-John, clinical psychologist*

**FIGURE 1. Many factors contribute to an individual's experience of pain**




A useful approach to communicating effectively within the therapeutic relationship is to change the paradigm from 'pain cure' to 'pain management'. Consider discussing the difference between acute and chronic pain, to explain why standard acute pain treatments ie, opioid analgesics, fail to treat chronic pain.[5]

As patients begin to understand and accept this shift in treatment focus, GPs can encourage them towards active self-management techniques. These include strategies learned from:

- a cognitive behavioural therapy (CBT) perspective – such as setting realistic goals, pacing activities and challenging unhelpful thoughts
- acceptance- and mindfulness-based interventions
- physical therapies that aim to gradually improve function despite persisting pain.[3,5]

Addressing each individual's pain condition from a biopsychosocial perspective and assessing how pain affects their life can also help to consolidate their understanding that the goals of pain management should go beyond pain relief alone.[4] Examples of goals include increased activity, improved physical function, and improved social, emotional and mental health.

Once goals are agreed upon, a coordinated pain management plan can be formulated and, where possible, this should involve collaboration between primary care, specialists and allied health professionals. Multidisciplinary pain management addresses the different aspects of chronic pain including the biopsychosocial impact on the individual (see Figure 1, previous page).[10,11]

The efficacy of a coordinated approach has been recognised to reduce pain severity, improve mood and overall quality of life and increase function.[10]

In addition to improving physical function, a biopsychosocial treatment approach to chronic non-cancer pain helps patients understand and overcome secondary effects, including fear of movement, pain catastrophising, and anxiety, that contribute to pain and disability.[10]

It is important to acknowledge that multidisciplinary pain management planning may be a difficult concept for some people, particularly if they are experiencing distress because of dealing with persistent pain, frustrated with having to attend multiple appointments and concerned about the financial impact of visiting several different providers.

*'One of the great dilemmas about the non-pharmacological approach is that these things take time, whereas a tablet takes maybe 15–20 minutes to take effect. So, making that shift from seeking a rapid reduction in unpleasant feelings through to investing in a time-consuming, effortful, long-term building of skill, is not an easy task.'*

*A/Professor Toby Newton-John, clinical psychologist*

# Encouraging self-management

Studies have indicated that the best care for chronic pain involves self-management by the patient with the support of a multidisciplinary team.[12–15]

This may include adhering to a prescribed medicine regimen and identifying their own treatment goals, then working to achieve those goals.[15]

There is good evidence that while a large proportion of people with chronic pain are capable of developing and effectively employing their own self-management strategies – such as goal-setting, thought challenging and activity pacing – many will need help acquiring these skills.[15]

The strongest evidence for delivering training in pain self-management for those with chronic disabling pain comes from structured multidisciplinary programs using cognitive behavioural therapy (CBT) methods.[15] Timely access to multidisciplinary pain management programs can be a barrier due to location and wait times, so GPs should be prepared to provide initial evidence-based information and upskill their patients in pain self-management strategies where possible.

*Try to persuade patients to stay active. I use exercise physiologists under chronic disease item numbers to get the patient to try a tailored exercise program. I suggest acupuncture, osteopathy, physiotherapy, frankly anything to try and stay away from opioids.*

*Dr Andrew Broad, GP*

# Optimising non-pharmacological therapies

Recent studies have found that, as a first-line treatment for patients with chronic non-cancer pain, non-pharmacological therapies may achieve similar degrees of improvement in pain and function to opioid therapy, but without the harms of opioid dependence, addiction and overdose.[13]

It is recommended that GPs and patients optimise non-pharmacological and non-opioid medicine therapy for chronic non-cancer pain within a biopsychosocial framework before considering opioids.[13]

Non-pharmacological therapies can include strategies described above, such as activity pacing and psychological therapies. They can also include education, structured exercise programs and sleep hygiene – with input where available from the wider health care team eg, nurse educator, physiotherapist, psychologist, occupational therapist, social worker, rehabilitation counsellor and dietitian.[8] With many different providers involved, care can become fragmented, so communication is vital. Usually the GP coordinates referral to providers and oversees a targeted treatment plan utilising available local resources.

## Cognitive behavioural therapy (CBT)

Cognitive behavioural therapy (CBT) helps patients to modify their emotional and behavioural response to pain by challenging cognitive processes eg, thoughts, fears and catastrophising about the pain.[4]

CBT has shown small positive effects on disability associated with chronic pain, and is effective in altering mood and catastrophising outcomes, with some evidence that this is maintained at six months.[16]

## Acceptance and mindfulness-based interventions

Acceptance and commitment therapy (ACT) focuses on psychological flexibility as the ultimate treatment goal.[17] In the context of chronic pain, being psychologically flexible means accepting painful sensations and the feelings and thoughts surrounding pain while focussing the attention on opportunities of the current situation rather than ruminating about the past or catastrophising about the future.[17,18] The behavioural focus of ACT is on setting goals that are important and valuable, instead of focussing on pain control.[18]

*Pain itself is an intrinsically unpleasant event, but if you're not careful you can take a perspective which makes an unpleasant event vastly more unpleasant.*

*The CBT techniques and some of the ACT techniques we use in chronic pain are designed to help people get their pain experience to the most adaptive perspective it can possibly be rather than lead to further distress or despair as a result of what's happening in their body.*

*A/Professor Toby Newton-John, clinical psychologist*

## Physical therapies and activity pacing

Physical therapies such as physiotherapy, occupational therapy, therapeutic exercise, and other movement modalities play a significant role in chronic pain management, and positive clinical outcomes are more likely if these therapies form part of a multidisciplinary treatment plan following a comprehensive assessment.[10]

A key feature of engaging in physical activity is known as activity pacing. Activity pacing is described in the literature as a coping strategy that involves activity behaviour that is goal-contingent rather than pain-contingent.[19]

*For most people with chronic pain, the more they do (overactivity), the more they hurt, and as a result of hurting more, they reduce their activity level (underactivity). This behaviour leads to what's called a boom and bust cycle. It's very frustrating and makes planning ahead difficult, if not impossible.*

*Activity pacing is about learning to rein yourself in – to regulate the amount of activity you engage in when you feel good – in order to have greater capacity to keep managing when you're not feeling so good.*

*A/Professor Toby Newton-John, clinical psychologist*

Although chronic pain is a complex and challenging area to manage, GPs and patients should be aware that several effective non-pharmacological therapies are available to support them (see Table 1, next page).

TABLE 1

## EXAMPLES OF NON-PHARMACOLOGICAL THERAPIES FOR CHRONIC NON-CANCER PAIN

| | |
|---|---|
| **ACTIVE PHYSICAL THERAPIES AND TECHNIQUES**[2,5,10] | ▸ general strengthening and gentle aerobic exercise (graded up slowly) eg, planned daily walks of gradually increasing distance<br>▸ hydrotherapy<br>▸ physiotherapy<br>▸ occupational therapy<br>▸ tai chi<br>▸ yoga |
| **PSYCHOLOGICAL THERAPIES**[2,5,10,16-18] | ▸ acceptance commitment therapy (ACT)<br>▸ attentional techniques (distraction from the pain)<br>▸ biofeedback<br>▸ cognitive behavioural therapy (CBT) on a one-to-one basis or in a group<br>▸ counselling<br>▸ relaxation training |
| **OTHER TREATMENT OPTIONS**[2,5,19-21] | ▸ activity pacing to regulate activity levels of everyday tasks eg, light housework, walking the dog<br>▸ acupuncture<br>▸ attending a group pain management program |

# When things get hard

Referral to pain management services may be warranted if patients have been unable to achieve their functional goals, or they are not progressing as expected. This may occur when current pain management measures are not helping and the pain is interfering in daily activities, causing distress and affecting the patient's mental health.[22]

## Managing patients with complex issues

People with chronic non-cancer pain should be appropriately assessed to determine the complexity of their needs and risk of harm.[23]

The following scenarios are generally considered complex and may be indicated for specialist and multidisciplinary review:

- taking two or more psychoactive drugs in combination (eg, opioids, benzodiazepines, antipsychotics, antiepileptics, depressants)
- taking opioids together with benzodiazepines
- patients with serious mental illness comorbidities or taking antipsychotic medicines
- mixing pharmaceutical opioids and illicit drugs
- discharged from other general practices due to problematic behaviour
- recent discharge from a correctional services facility
- signs of potential high-risk behaviours.

Some GPs will be confident managing patients with mental health and substance use comorbidities while others may wish to seek specialist support.[23]

People who are at higher risk of opioid misuse, or have more complex issues, may need to be jointly managed between primary care, pharmacists, drug and alcohol services, and specialist services (eg, mental health, pain or addiction specialists).[23]

The risk of harm from opioids increases for patients on high doses, patients with complex comorbidities and those who are co-prescribed benzodiazepines and other sedatives.[24]

### Take home naloxone

Discussion about take-home naloxone (THN) as part of an overdose response plan is an effective brief intervention.[4,25] The use of naloxone fits within both harm reduction strategies and patient-centred care. Naloxone is safe, effective, inexpensive, and relatively easy to administer via intramuscular (IM) injection or intranasal spray.[4]

Prescribers are encouraged to provide a prescription for THN for patients at high risk of overdose eg, high opioid dose, complex care, or recently released from a correctional services facility.[4]

For more information:

- Community Overdose Prevention Education (COPE) Overdose First Aid
- Talking to patients about naloxone
- Australian Government Take Home Naloxone Pilot

# Conclusion

Non-pharmacological therapies have the potential to improve outcomes for chronic pain and comorbidities and tend to be low risk.[12]

GPs and patients can work together to formulate a pain management plan which includes multimodal non-pharmacological approaches that can be implemented through patient self-management supported by a trusting therapeutic relationship over multiple consultations.[12]

*So, the saying the journey of a thousand miles begins with one step is very true in this case.*

*A/Professor Toby Newton-John, clinical psychologist*

# Useful links for your patients

- NPS MedicineWise, Chronic pain explained
- NPS MedicineWise, Opioid medicine and chronic non-cancer pain
- ACI NSW Pain management network, Pain Management: For everyone
- ACI NSW Pain management network, Pain and thoughts. A video about how negative thoughts and stressful life situations can influence pain
- Hunter New England Local Health District, Understanding pain in less than 5 minutes, and what to do about it! A video that summarises the difference between acute and chronic pain
- Pain Australia, List of pain services in Australia
- PainHealth, Pacing and goal setting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