



## Regular use of prescribed opioids: Association with common psychiatric disorders

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Received 2 June 2005; received in revised form 18 August 2005; accepted 12 September 2005

### Abstract

Use of opioids for chronic non-cancer pain is increasing, but the clinical epidemiology and standards of care for this practice are poorly defined. Psychiatric disorders are associated with increased physical symptoms and may be associated with opioid use. We performed a secondary analysis of cross-sectional data from the Health Care for Communities (HCC) survey conducted in 1997–1998 ( $N=9279$ ) to determine the association of psychiatric disorders and self-reported regular use of prescribed opioids within the past year. Regular prescription opioid use was reported by 282 (3%) respondents. In unadjusted logistic regression models, respondents with common mental disorders in the past year (major depression, dysthymia, generalized anxiety disorder, or panic disorder) were more likely to report regular prescription opioid use than those without any of these disorders (OR=6.15, 95% CI=4.13, 9.14,  $P < 0.001$ ). Respondents reporting problem drug use (OR=4.75, 95% CI=2.52, 8.94,  $P < 0.001$ ), or problem alcohol use (OR=1.89, 95% CI=1.03, 3.40,  $P = .041$ ) reported higher rates of prescribed opioid use than those without problem use. In multivariate logistic regression models controlling for demographic and clinical variables, the presence of a common mental disorder remained a significant predictor of prescription opioid use (OR=3.15, 95% CI=1.69, 5.88,  $P < 0.001$ ), among individuals reporting low pain interference ( $N=8307$ ); but not (OR=1.27, n.s.) among those reporting high pain interference ( $N=972$ ). Depressive, anxiety and drug abuse disorders are associated with increased use of regular opioids in the general population. Depressive and anxiety disorders are more common and more strongly associated with prescribed opioid use than drug abuse disorders.

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**Keywords:** Opioids; Psychiatric disorder; Chronic non-cancer pain; Depression; Anxiety

### 1. Introduction

From 10 to 20% of the general population are significantly affected by chronic non-cancer pain (CNCP) (Von Korff et al., 2005). Following successful cancer pain initiatives, efforts have been made to liberalize the use of opioids for the treatment of these individuals. In a 1996 joint statement, the American Pain Society and the American Academy of Pain Medicine declared that concerns about addiction, respiratory depression, tolerance and diversion had been overstated and that “the use of opioids for the relief of chronic pain is a legitimate medical practice” (1997). In

Great Britain, a similar consensus statement issued in 2004 recommends a trial of opioids as part of an overall rehabilitation strategy for patients with persistent pain (Royal Pain Society, 2004). These efforts are based on the belief that patients with CNCP deserve pain relief equally to those with cancer and that sustained pain relief is possible with stable doses of opioids.

There is evidence in recent years of increasing use of prescription opioids for CNCP. Between 1980 and 2000, the rate of opioid prescribing at outpatient visits for chronic musculoskeletal pain doubled from 8 to 16% of visits (Caudill-Slosberg et al., 2004). Another study showed a marked increase in both use and abuse of prescribed opioids between 1997 and 2002 (Gilson et al., 2004). While some pain specialists have seen the growth in opioid prescribing

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as evidence of better attention to the problem of unrelieved pain (Portenoy, 2004), others have expressed concern that we have not had adequate trials to prove the “safety and effectiveness of long-term opioid therapy” in CNCP (Von Korff and Deyo, 2004). It has indeed been difficult to define standards of care in this area.

Despite these increasing and variable rates of opioid prescribing, little is known about the clinical epidemiology of opioid use for CNCP. Although depression is very common in patients treated for CNCP in pain clinics (Banks and Kerns, 1996), the role of mental disorders in the general population treated with opioids for CNCP is not clear. Prospective surveys of primary care populations suggest that chronic pain promotes depression and that depression promotes chronic pain equally strongly (Gureje et al., 2001). Studies with small clinical samples suggest that patients with mental disorders may be more likely to receive opioids for CNCP (Breckenridge and Clark, 2003; Reid et al., 2002; Turk and Okifuji, 1997). This study further investigates the role of mental health and substance abuse disorders in the regular use of opioids with data from a large, nationally representative, population-based survey, Healthcare for Communities (HCC). On the basis of these earlier studies we hypothesized that individuals with common mental disorders (e.g. depression and anxiety) or substance abuse would be more likely to report regular use of prescribed opioids than those without common mental disorders, controlling for level of pain-related interference and other possible confounders.

## 2. Methods

### 2.1. Sample

Data are from Healthcare for Communities (HCC), a part of the Robert Wood Johnson Foundation’s Health Tracking Initiative. HCC was a nationwide telephone survey designed to track the effects of the changing health care system on individuals at risk for alcohol, drug abuse, and mental health (ADM) disorders (Sturm et al., 1999). The use of a large, community-based sample such as HCC offers several distinct advantages for this type of analysis. First, it minimizes the bias that might occur when using data from only a limited number of practice settings or patient groups; this is especially important when studying a therapy whose use is thought to vary widely, such as opioids for CNCP. Further, the large sample size of HCC, and the resultant statistical power, allows meaningful subgroup analysis. Because this is a cross-sectional survey, it is not possible to assign causal priority to the psychiatric disorder, chronic pain condition, or opioid use.

The HCC respondents were a stratified probability sample of participants in the Community Tracking Study (CTS), a nationally representative study of the US civilian population during 1996–1997 (Kemper et al., 1996). The CTS includes a sample clustered within 60 randomly selected US communities and a national sample. To improve power for analyses of individuals with ADM disorders and treatment utilization, HCC over-sampled the following four groups of CTS respondents: (1) the CTS national

sample, (2) individuals with family income below \$20,000, (3) individuals with high psychological distress on a scale consisting of two items from the 12-item Short Form Health Questionnaire (SF-12) (Ware et al., 1996) and (4) individuals with any ADM specialty care utilization during the prior year. HCC was conducted in 1997–1998. Of the 14,985 respondents selected for HCC, 9585 complete interviews were obtained, for a response rate of 64%. We use the sample weights designed by the statisticians on the HCC study staff to weight the data so that they would again be representative of the US population and adjusted for the probability of selection, non-response, and the number of households in the CTS survey that did not have a phone. We excluded respondents reporting cancer diagnoses other than skin cancer within the past 3 years ( $N=217$ ) to isolate non-cancer pain. Those missing data for key variables ( $N=89$ ) were also excluded, resulting in a sample size of 9279. Informed consent was obtained verbally before the interview, and the study was approved by the institutional review boards at UCLA and RAND.

### 2.2. Dependent variable

*Regular use of prescribed opioids.* HCC respondents were asked about all prescribed medications which they had taken “at least several times a week for a month or more” in the past 12 months. Respondents were asked to read the names directly off of their pill bottles to the interviewers, for all of their medications. These medications were later grouped into therapeutic categories by study staff. In our sample, 96% of the 282 subjects reporting this level of opioid use specifically confirmed that the opioid was prescribed, and 79% confirmed opioid use for at least 2 months. (As a sensitivity analysis, we ran our models with the sample restricted to those participants who verified use of at least 2 months. The odds ratios derived for common mental disorders were similar but somewhat larger.) From this we constructed a dichotomous measure of regular prescription opioid use as our dependent variable, with 282 individuals reporting regular opioid use of at least one month.

### 2.3. Independent variables

Our model specification is based on the work of Andersen (1995) who posited that access to medical treatment is a function of patient need, predisposing factors, and enabling factors. We used several complementary measures of physical health and chronic physical conditions as measures of patient need for opioid treatment. These included the Physical Component Summary-12 (PCS-12), an aggregate measure of physical health functioning, and a measure of self-reported health (excellent, very good, good, fair, or poor), both from the SF-12. The HCC contains information on 17 self-reported chronic medical conditions. Our final models included variables representing those medical conditions that were associated with opioid use (bivariate  $r > 0.1$ ): chronic lower back pain, chronic headaches, and other chronic pain. We also included a dichotomous measure of pain interference with the respondents’ daily activities derived from the SF-12 pain item (extremely/a lot vs. moderately/a little bit/not at all).

The prevalence of common mental disorders in the past 12 months (major depression, dysthymia, generalized anxiety disorder (GAD), and panic disorder) was assessed using short-form versions (Kessler et al., 1998) of the World Health Organization’s

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