TREATING PAIN AND CO-MORBID OPIOID USE DISORDER

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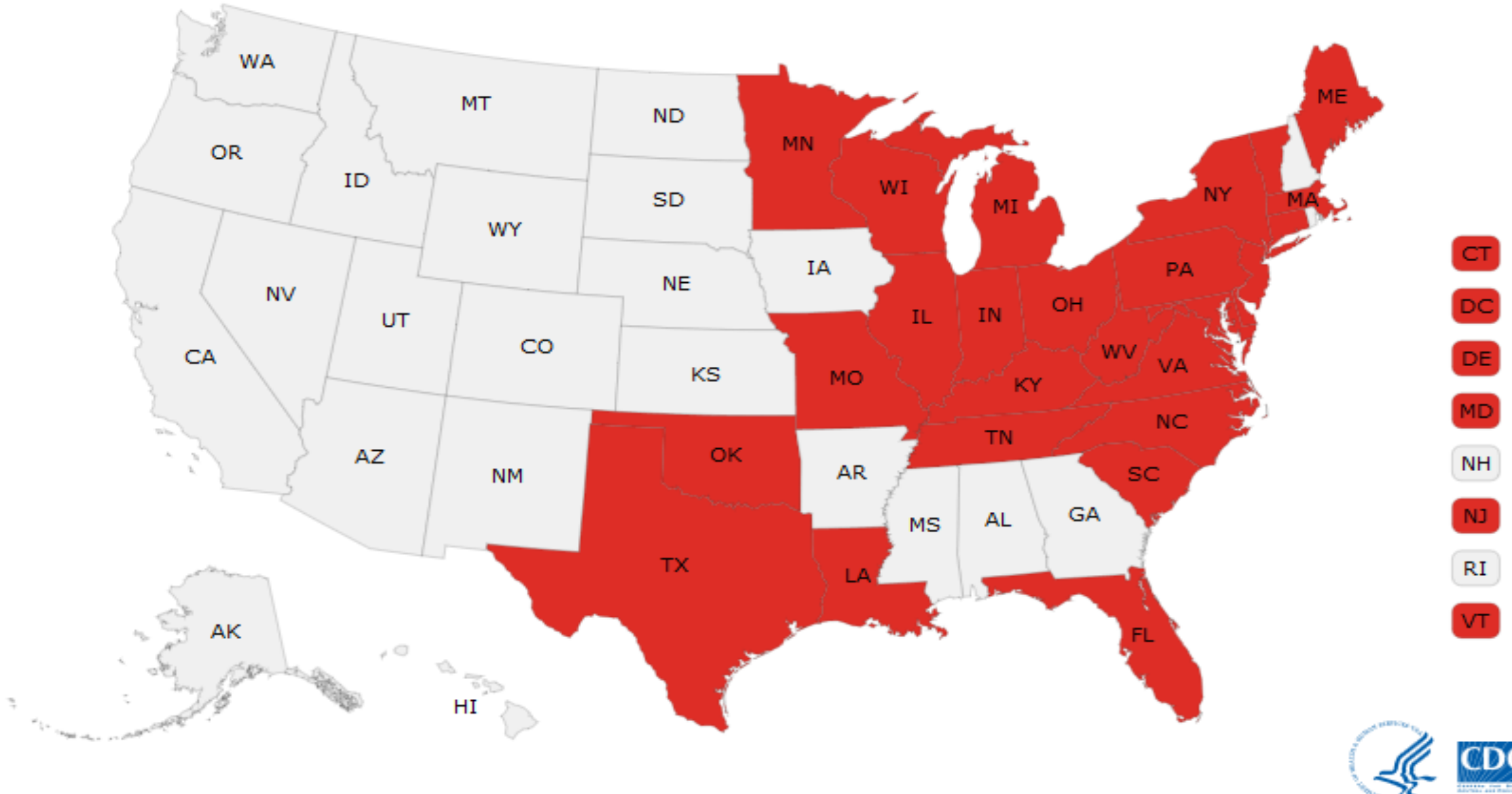
DISCLAIMER

The views expressed in this presentation are solely those of the presenter and do not represent those of the Veterans Health Administration or the United States government.

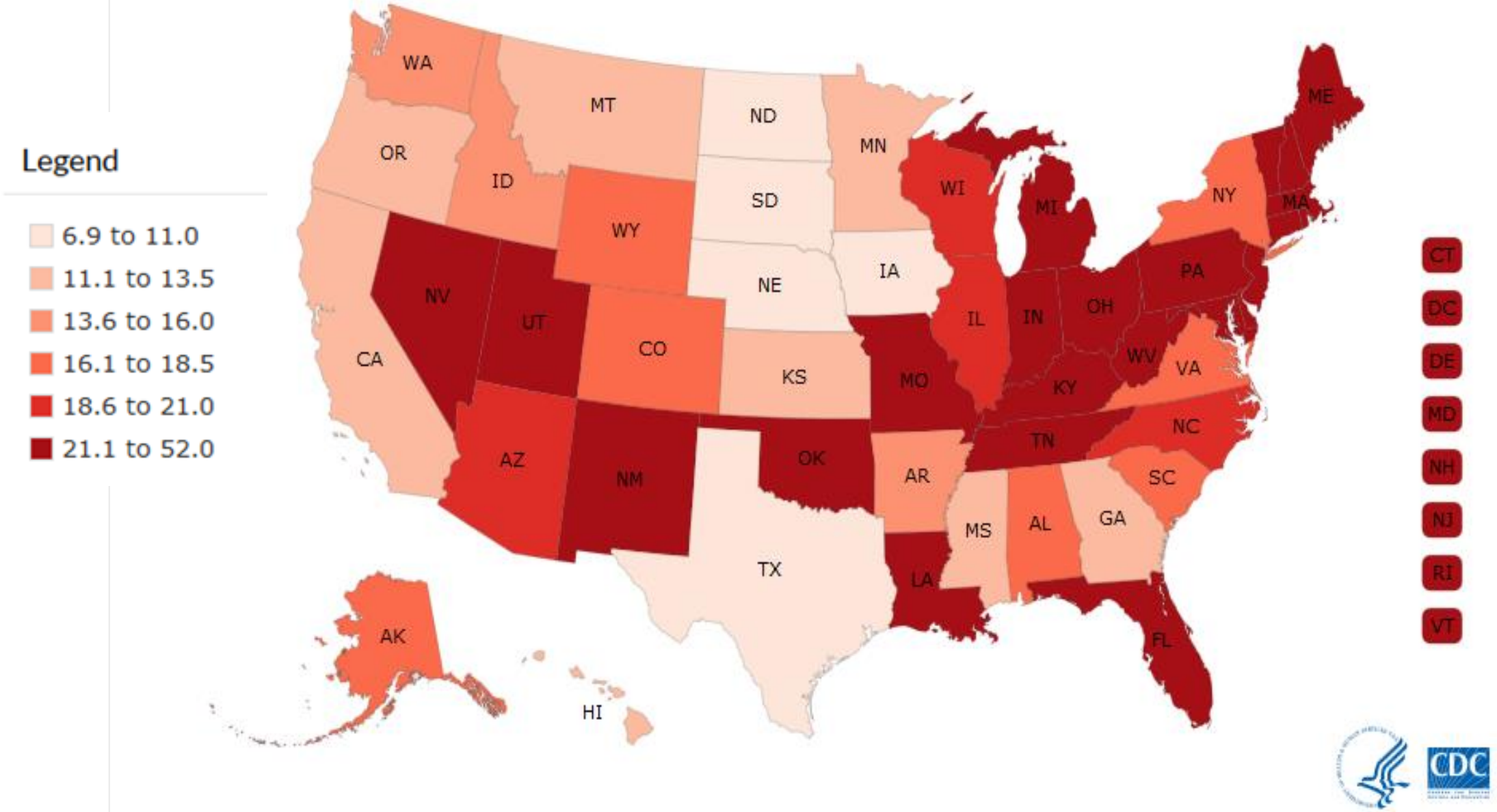
The presenter has no conflicts of interest to disclose.

THE OPIOID CRISIS

Statistically significant drug overdose death rate increase from 2015 to 2016, US states

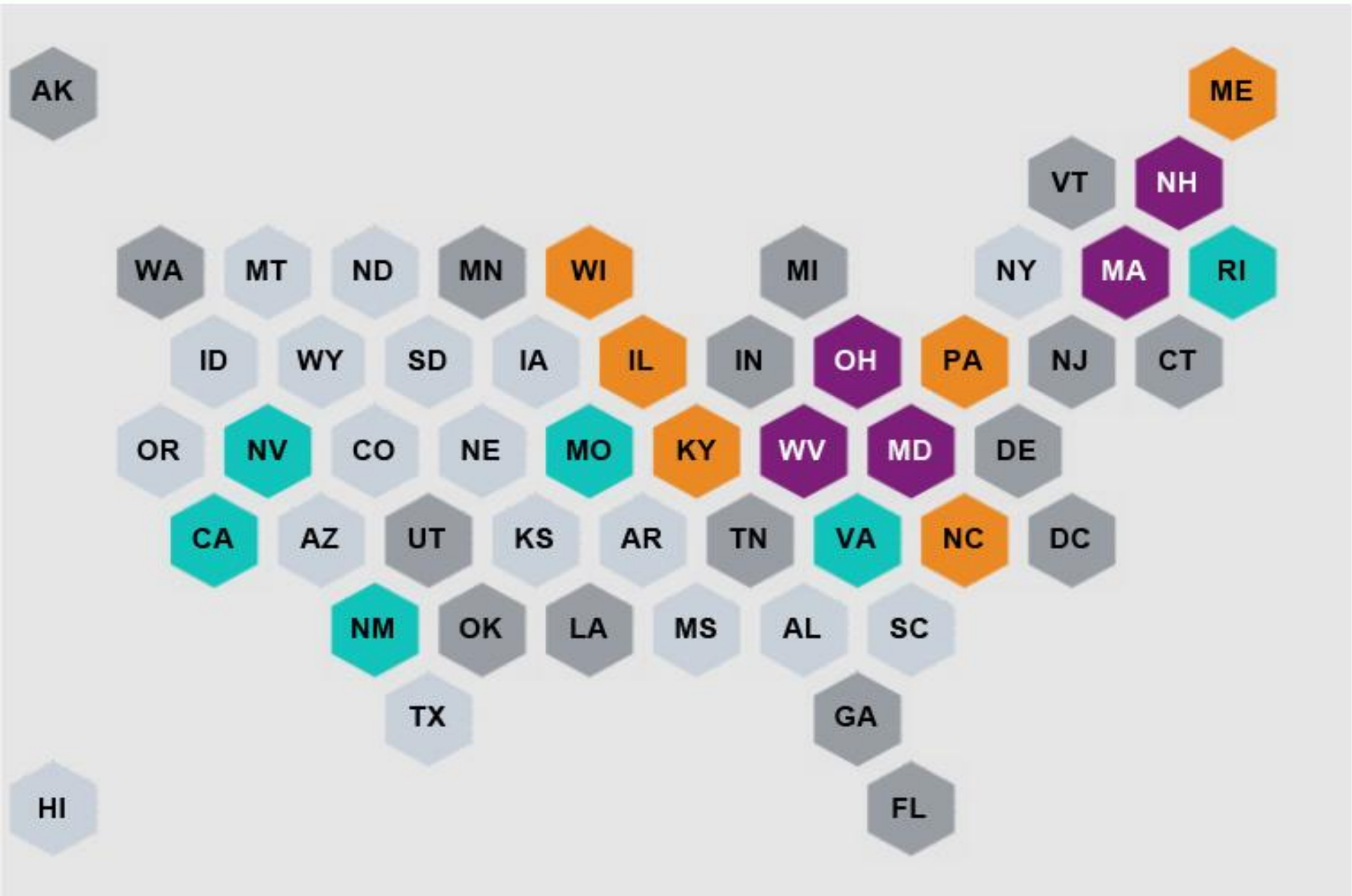


Number and age-adjusted rates of drug overdose deaths by state, US 2016



Trends in Emergency Department Visits for Suspected Opioid Overdose, Q4 2016 to Q4 2017

CDC's Enhanced State Opioid Overdose Surveillance Program



LEGEND

- Significant increase
- No significant change
- Significant decrease
- Data not available/not reported
- Unfunded state

At the core of the opioid crisis are two related problems: addiction and pain

THE RELATIONSHIP BETWEEN PAIN AND OPIOID ADDICTION

IT ALL STARTED WITH

THE INTRODUCTION OF OPIUM FOR PAIN RELIEF

When pain began to be seen as a medical problem, physicians turned to opium, a substance derived from the poppy flower.

THE CIVIL WAR ERA

"A Federal surgeon devised a speedier sick call method. He performed diagnosis from horseback, dispensing morphine powder by pouring it into his hand and letting the patient lick it."

"Maimed and shattered survivors from a hundred battlefields… have found, many of them, temporary relief from their sufferings in opium." *The Opium Habit,* 1868

Civil War Times, May, 1988

THE LETTER

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients[1] who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,[2] Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

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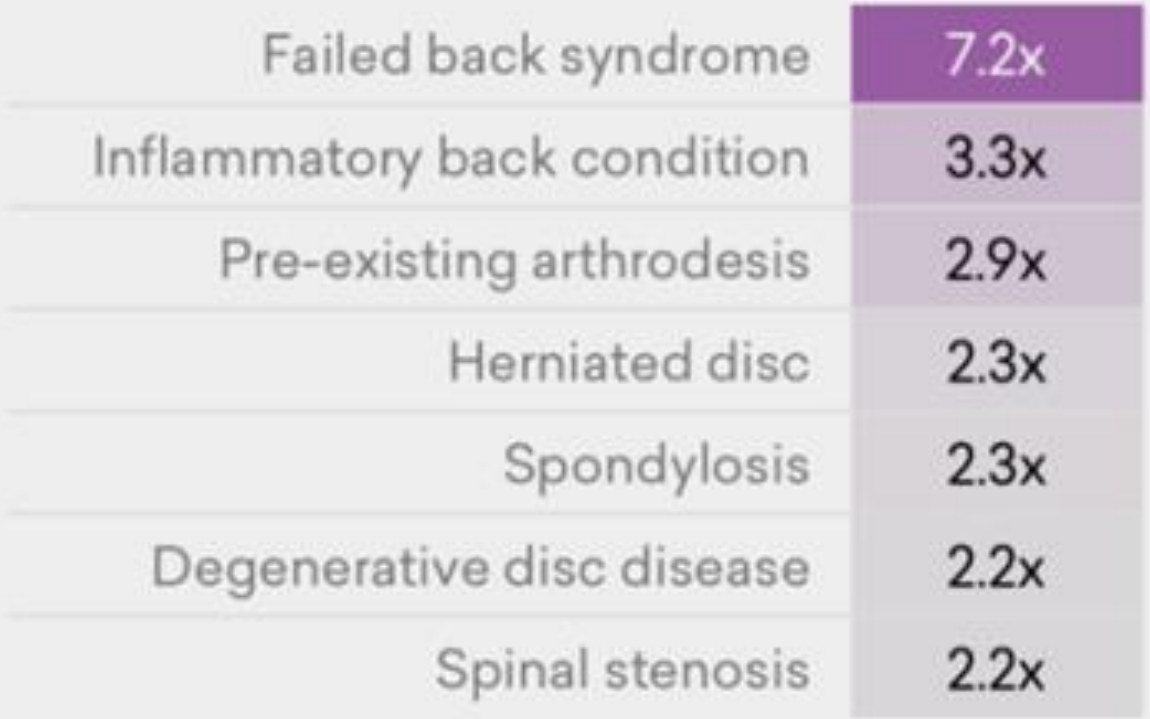
1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind Y, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.

OTHER CONTRIBUTING FACTORS

- The designation of pain as “the fifth vital sign” in 1995 by the American Pain Society
- The development of new opioids that were aggressively marketed by pharmaceutical companies
- The development of managed care

Patients diagnosed with opioid use disorder are more frequently diagnosed with...

Relative frequency ratios of select conditions among patients diagnosed vs. not diagnosed with opioid use disorder



"Failed back syndrome" represents a group of chronic pain conditions following back surgeries, and is **7.2 times** more frequently diagnosed among patients also diagnosed with opioid use disorder versus patients not diagnosed with opioid use disorder.

PAIN AND OPIOID USE

- 126 million Americans (55.8%) report some pain over the previous three months (Nahin, 2012)
- 25.3 million, or 11.2%, report chronic pain (Nahin, 2012)
- The most common reason for opioid misuse is pain, accounting for 63.4% of opioid misusers (NSDUH, 2017)

ADDICTION AND CHRONIC PAIN

Addiction increases the risk for chronic pain through several mechanisms (Bruinjzeel et al., 2004)

- Development of Tolerance and Physical Dependence
- Anxiety and Affective Disorders
- Sleep Disorders
- Sympathetic Arousal
- Increased stress with HPA axis activation
- Increased risk for trauma

WHAT CAN WE DO ABOUT ADDICTION TO OPIOIDS?

PSYCHOSOCIAL INTERVENTIONS FOR OPIOID ADDICTION ARE INEFFECTIVE

- 80% of patients return to regular opioid use within two years after residential treatment (Keen et al., 2001; Kosten & Gorelick, 2002)
- A Cochrane review concluded that the available evidence does not support psychosocial treatment alone for OUDs (Mayet et al., 2005)
- Medically assisted detoxification plus psychosocial support does not result in abstinence beyond initial stabilization (Fullerton et al., 2014; Sees et al., 2000; Ling et al., 2009)
- Medication-assisted therapy is more effective than psychosocial interventions (Fullerton et al., 2014)
  - Methadone maintenance results in greater treatment retention and fewer positive urine drug screens (Mattick et al., 2003)

MEDICATION-ASSISTED THERAPY

- Medication-Assisted Therapy is the use of FDA-approved medications to treat opioid, alcohol, and stimulant use disorders
- MAT is the gold standard in Opioid Use Disorder treatment
- The goals of MAT (SAMHSA, 2015) are to:
  - Relieve withdrawal symptoms and psychological cravings
  - Block the euphoric effects of substances
  - Normalize brain chemistry
  - Normalize body functions without substances
- Medications approved for treatment of opioid use disorders:
  - Methadone
  - Buprenorphine or Suboxone (buprenorphine + naloxone)
  - Naltrexone (Vivitrol)

METHADONE

- An opiate agonist
- Available in tablet, wafer, and liquid forms
- Patients begin by coming for daily dose
  - Over time, can work up to weekly, biweekly, monthly
- Methadone is not helpful for pain management, as its analgesic effects last only 6 hours (Buchholz & Saxon, in Matthews & Fellers, 2016)
- Methadone maintenance improves treatment retention and reduces heroin use compared to psychosocial interventions (Mattick et al., 2009)

BUPRENORPHINE

- Partial opiate agonist
- Available in tablets, film, and a transdermal patch used for pain management
- Cannot be administered safely until last dose of opioids was 4-6 hours earlier (Buchholz & Saxon, 2016)
- Buprenorphine is more effective than placebo (Veilleux et al., 2010)
- Suboxone deters diversion because the user will experience withdrawal from the naloxone (Subramaniam et al., 2011)

NALTREXONE

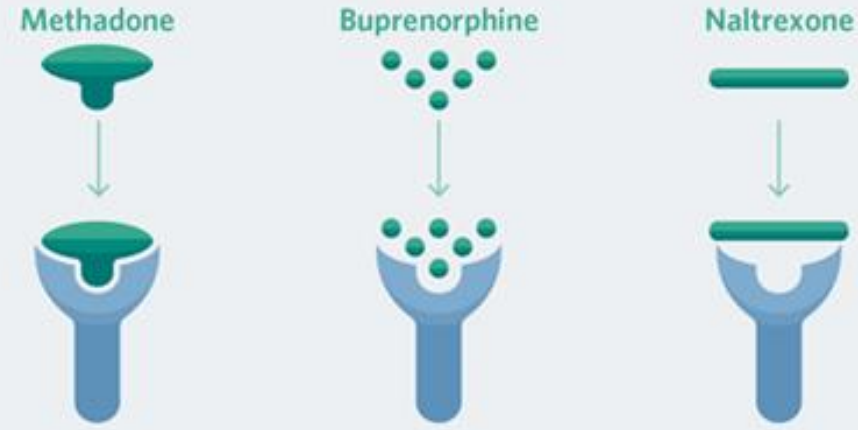
- An opiate antagonist
- Available as tablets or a monthly injection
- Patients must not have taken opioids for 7-14 days (Connery, 2015)
  - It requires full detoxification to be used safely
- Results in fewer positive urine tests for opioids and lower criminal justice recidivism rates compared to non-users (Coviello et al., 2010)

Medication Assisted Treatment			
	Suboxone	**Methadone**	**Vivitrol**
Medication	Buprenorphine/Naloxone	Methadone	Naltrexone
Mechanism of Action	Partial Opioid Agonist	Long Acting Opioid	Opioid Antagonist
Half Life	24 - 60 hours	24 - 55 hours	5-10 days
Cost	$$$	$	$$$$
Overdose Potential	Minimal	Minimal - Moderate	None
Dosing	1-2 times per day Max of 24mg daily	Varies. Average ~40-120 mg daily. No max daily dosage.	380 mg monthly
Dependence Potential	Minimal	Moderate	None
Pain Relief?	Yes	Yes	No

Figure 1

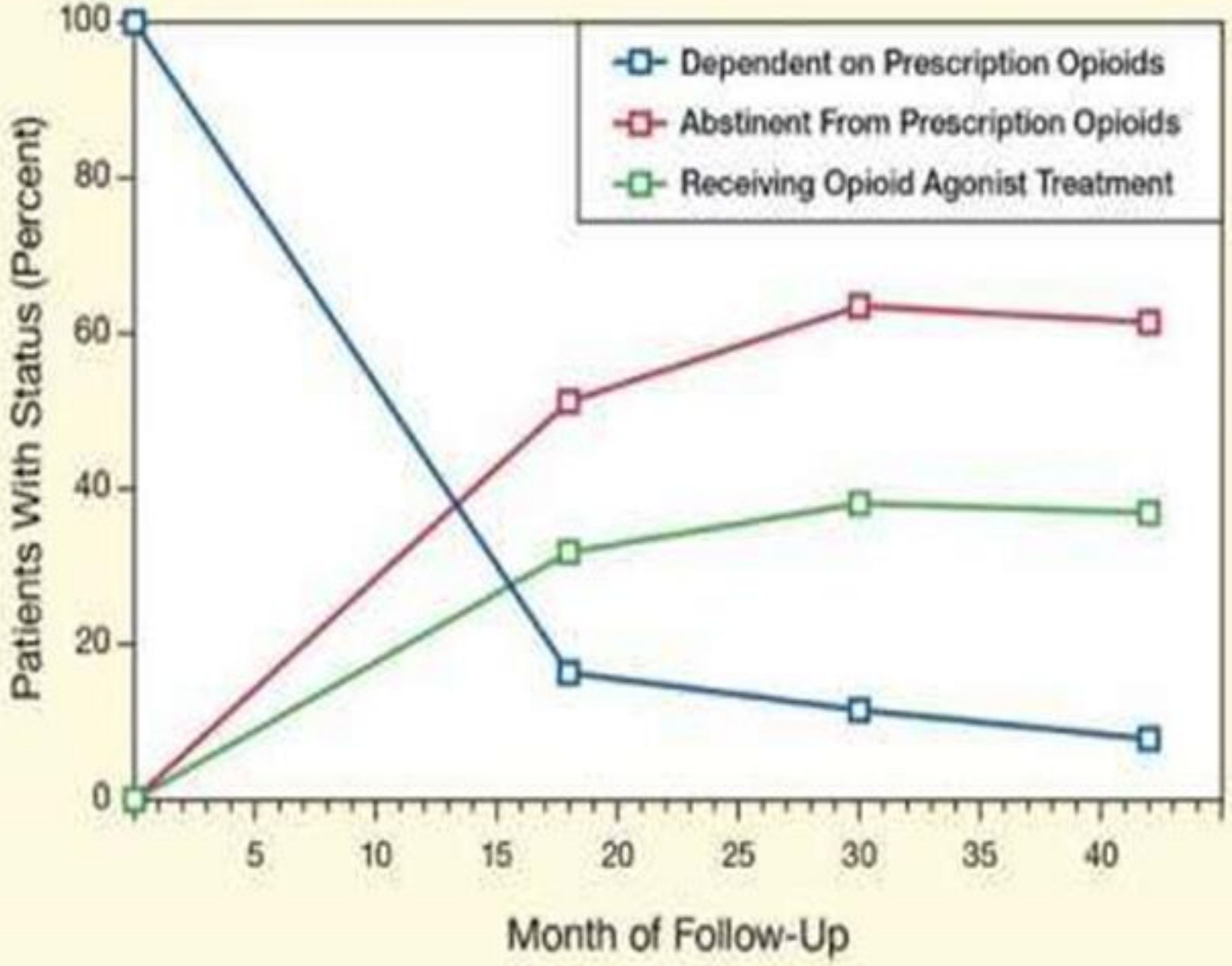
How OUD Medications Work in the Brain

Empty opioid receptor

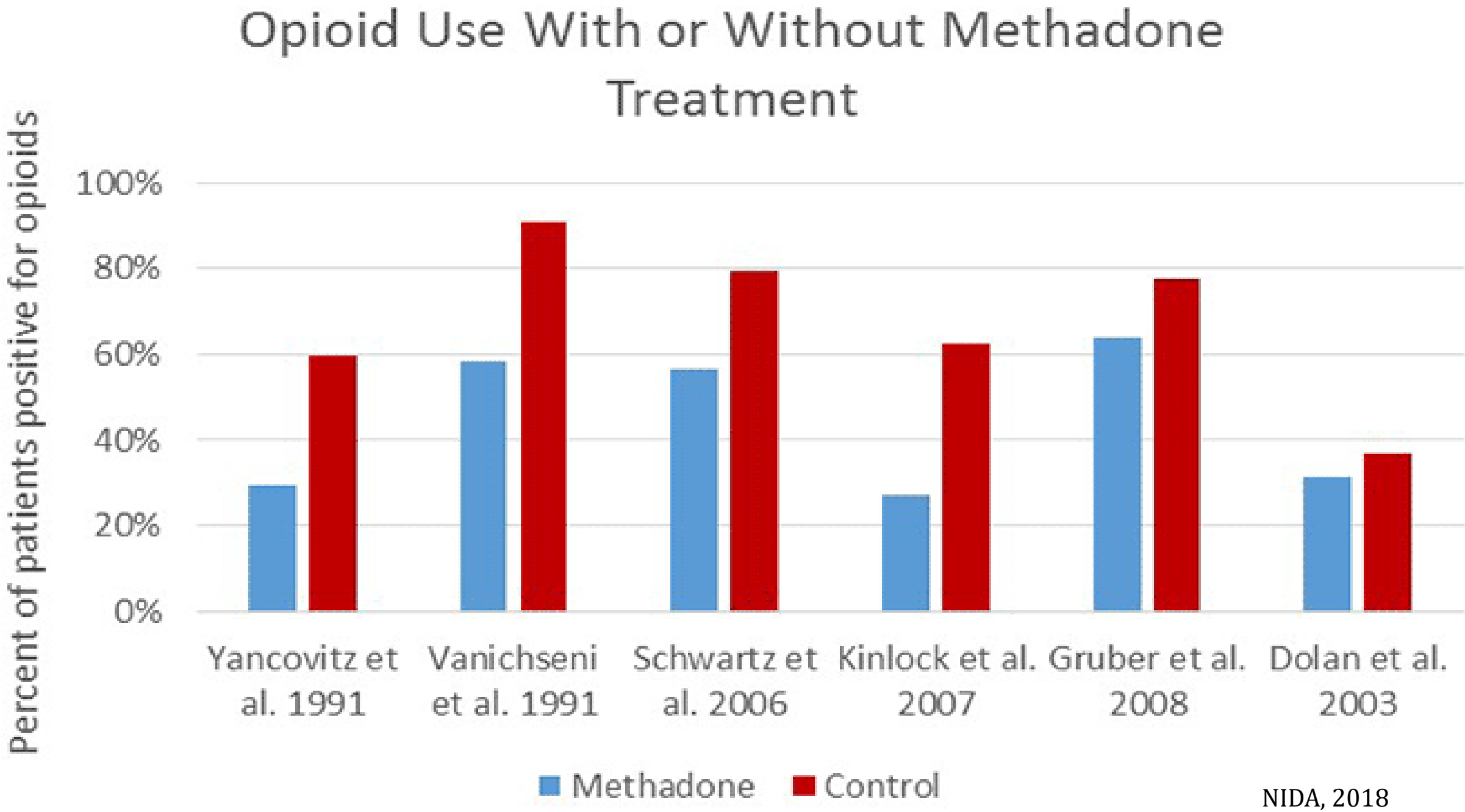


HOW DOES MAT WORK?

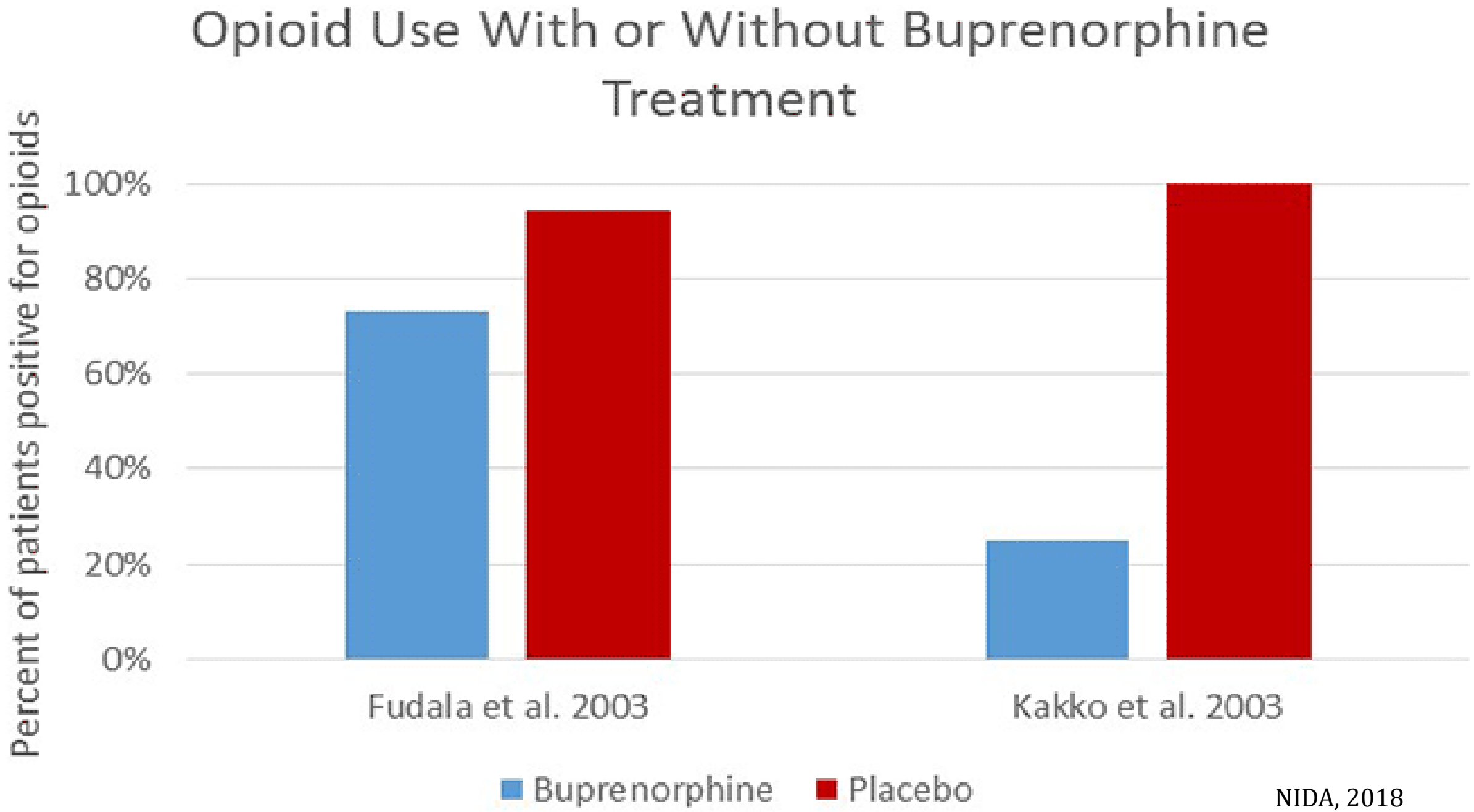
MAT IS EFFECTIVE



Weiss et al., 2015


Opioid Use With or Without Methadone Treatment
Percent of patients positive for opioids
100%
80%
60%
40%
20%
0%
Yancovitz et al. 1991
Vanichseni et al. 1991
Schwartz et al. 2006
Kinlock et al. 2007
Gruber et al. 2008
Dolan et al. 2003
Methadone
Control

NIDA, 2018


Opioid Use With or Without Buprenorphine Treatment
Percent of patients positive for opioids
100%
80%
60%
40%
20%
0%
Fudala et al. 2003
Kakko et al. 2003
Buprenorphine
Placebo

NIDA, 2018

BUPRENORPHINE MAINTENANCE IMPROVES ODDS OF SUCCESSFUL RECOVERY 10-FOLD

Phase 2 Time Point	Observed, No./Total No. (%) [95% Confidence Interval (CI)]	Odds Ratio (95% CI)	P Value
End of treatment	177/360 (49.2) [43.9-54.5]	10.6 (7.2-15.6)	<0.001
8-week posttreatment follow-up	31/360 (8.6) [5.9-12.0]		

Weiss R et al: 2011;Arch Gen Psych

ADVANTAGES OF MAT

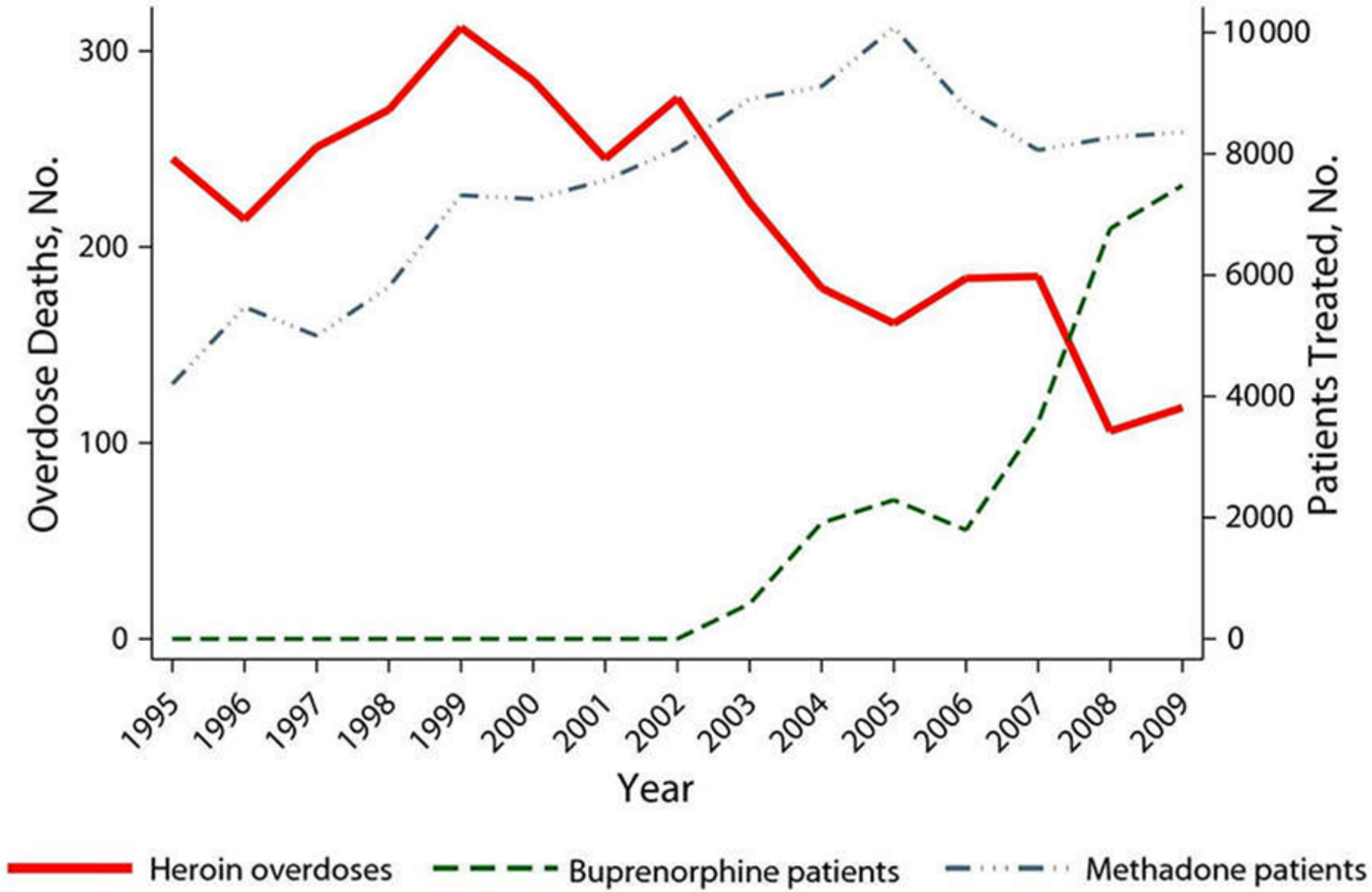
- MAT increases treatment retention
- It decreases illicit opiate use and other criminal activity in people with Substance Use Disorders (SUDs) (Krebs et al., 2017)
- It increases patients' abilities to gain and maintain employment
- It improves birth outcomes among pregnant women with SUDs
- It can lower a person's risk of contracting HIV or Hepatitis C by reducing the potential for relapse (NIDA, 2012)
- It is cost effective and provides more health benefits than treatment without medication (Connock et al., 2007)
- MAT saves lives

SAMHSA, 2015

MAT SAVES LIVES

- Buprenorphine and Methadone save lives (Wikner et al., 2014)
- Buprenorphine and Methadone reduce mortality rates by two-thirds (Sordo et al, 2017)
- Naltrexone also saves lives (Krupitsky et al., 2013)

MAT REDUCES HEROIN OD DEATHS



Location: Baltimore, MD

Schwartz et al., 2013

COMPARING METHADONE, BUPRENORPHINE, AND SUBOXONE

Methadone

- Is cheapest
- Has the most side effects
- Has the most drug-drug interactions
- Is easiest to induce
- Daily dosing requires monitoring
- Is easiest to abuse/divert
- Has the highest retention rate at high doses
- Is most heavily regulated; facilities require certification

Buprenorphine/ Suboxone

- Is mid-priced
- Safer than methadone
- Can be induced at 4-6 hours
- No monitoring needed
- Divertable as buprenorphine alone to reduce withdrawal symptoms, not as suboxone
- High retention rate

Naltrexone

- Is most expensive
- Is safest except when patient has used recently
- Is hardest to induce; wait is 7-14 days
- Can be injected in a monthly dose
- No monitoring needed
- Has no diversion value
- Retention only after induction

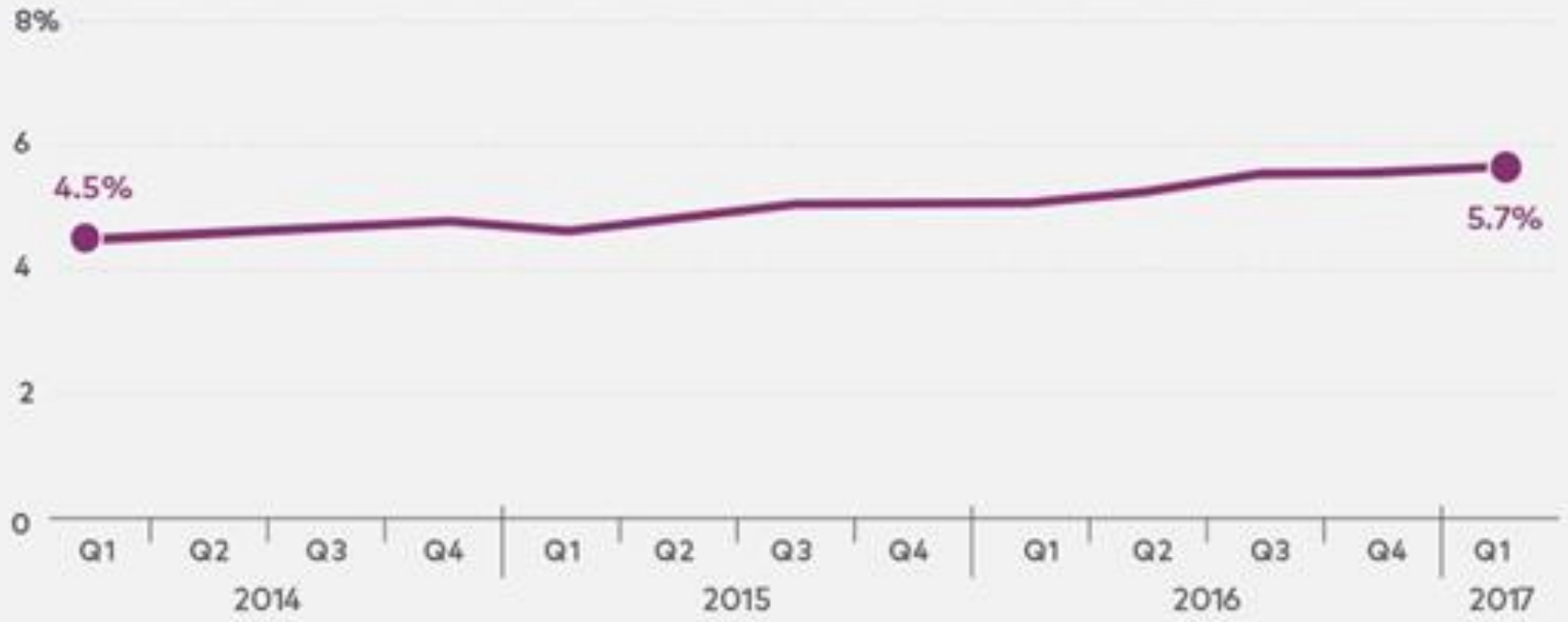
SUBOXONE VS. NALTREXONE

- A recent RCT of Suboxone vs. Vivitrol (Lee et al., 2017) in 570 participants found:
  - No differences in safety
  - No differences in effectiveness
  - A significant difference in successful induction rates
    - 94% of Suboxone users successfully initiated vs. 72% of Naltrexone users
    - 65% of Naltrexone users relapsed at 24 weeks, vs. 58% of Suboxone users
    - 89% of the difference was due to Naltrexone induction failure
    - Among those successfully induced, both were equally effective
- *This suggests that you should consider trying Suboxone first*

CURRENT USAGE OF MAT IS LIMITED

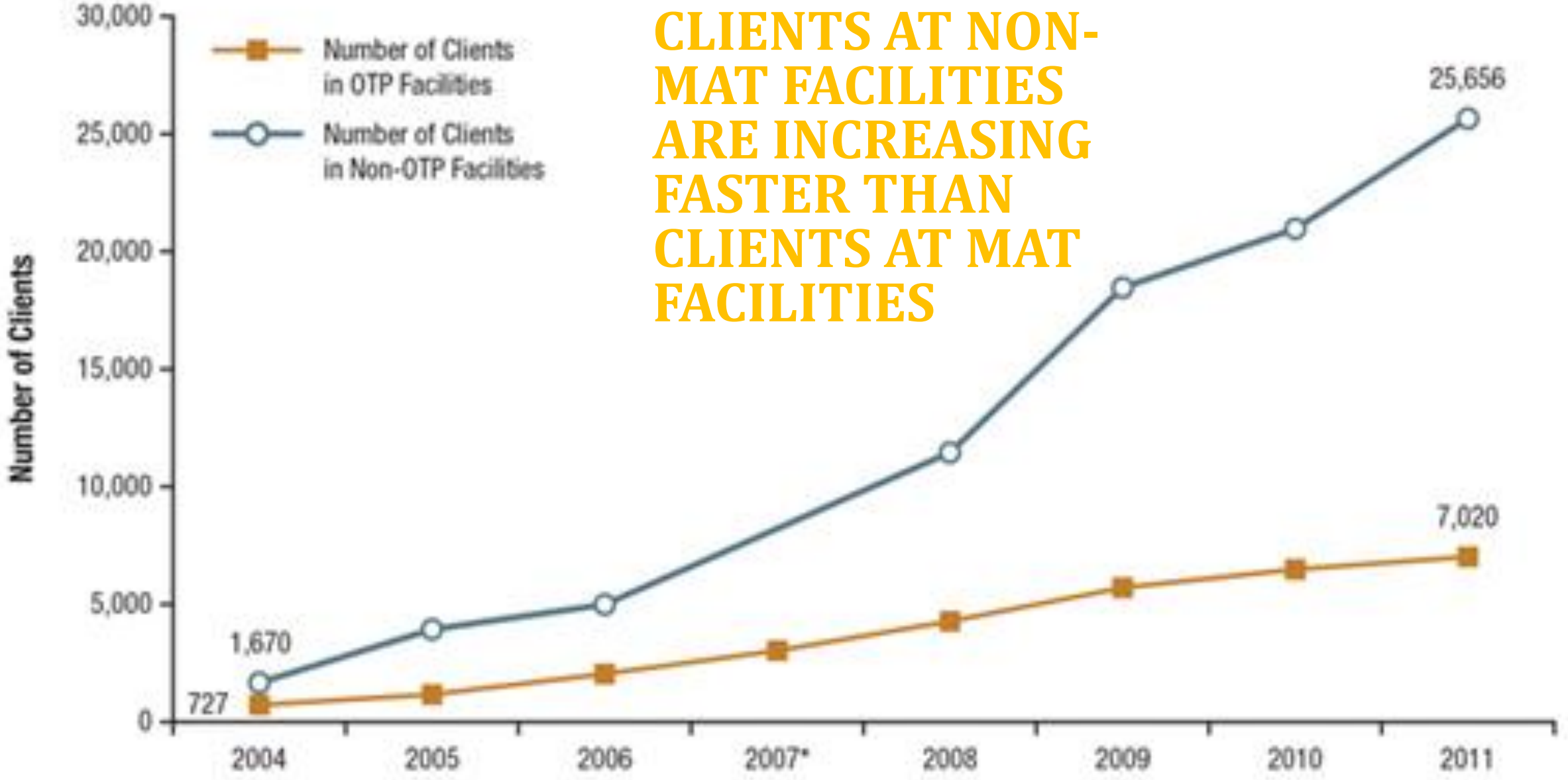
- Only 21% of people with Opioid Use Disorders receive treatment (SAMHSA, 2016)
- The proportion of heroin admissions that received MAT declined from 35% in 2002 to 28% in 2012 (SAMHSA, 2014)
- Less than half of privately-funded SUDs treatment programs offer MAT, and only 1/3 of patients with OUDs actually receive it (ACOG & ASAM, 2012)
- Almost all states have insufficient treatment capacity to provide MAT to all patients with OUDs (Knudsen et al., 2011)
- Stigma prevents many people from using MAT (Frank, 2011)
- Only small numbers of primary care providers are willing to prescribe it

Percent of providers prescribing drugs for opioid dependence



Source: athenaResearch
Sample: Approximately 2,500 primary care providers active on athenaNet since 2014 with at least 10 opioid prescriptions written each quarter

CLIENTS AT NON-MAT FACILITIES ARE INCREASING FASTER THAN CLIENTS AT MAT FACILITIES



* Due to data limitations, it is not possible to report non-OTP 2007 statistics.

Source: SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS), 2004 to 2011.

SAMHSA, 2013

MYTHS ABOUT MAT

Myth #1: Methadone and buprenorphine substitute one addiction for another.

Fact: Methadone and buprenorphine do not get people high. They reduce opioid cravings and withdrawal and restore balance to brain circuitry so that the patient's brain can heal (SAMHSA, 2016). Taking medication as prescribed allows patients to hold jobs, avoid street crime, and reduce exposure to HIV (NIDA, 2018).

Myth #2: Diversion of buprenorphine is common.

Fact: Diversion of buprenorphine is uncommon, and is primarily used to manage withdrawal (Bazazi et al., 2011; Schuman-Olivier et al., 2010). Diversion of oxycodone and hydrocodone are much more common (DEA, 2014).

MYTHS ABOUT MAT

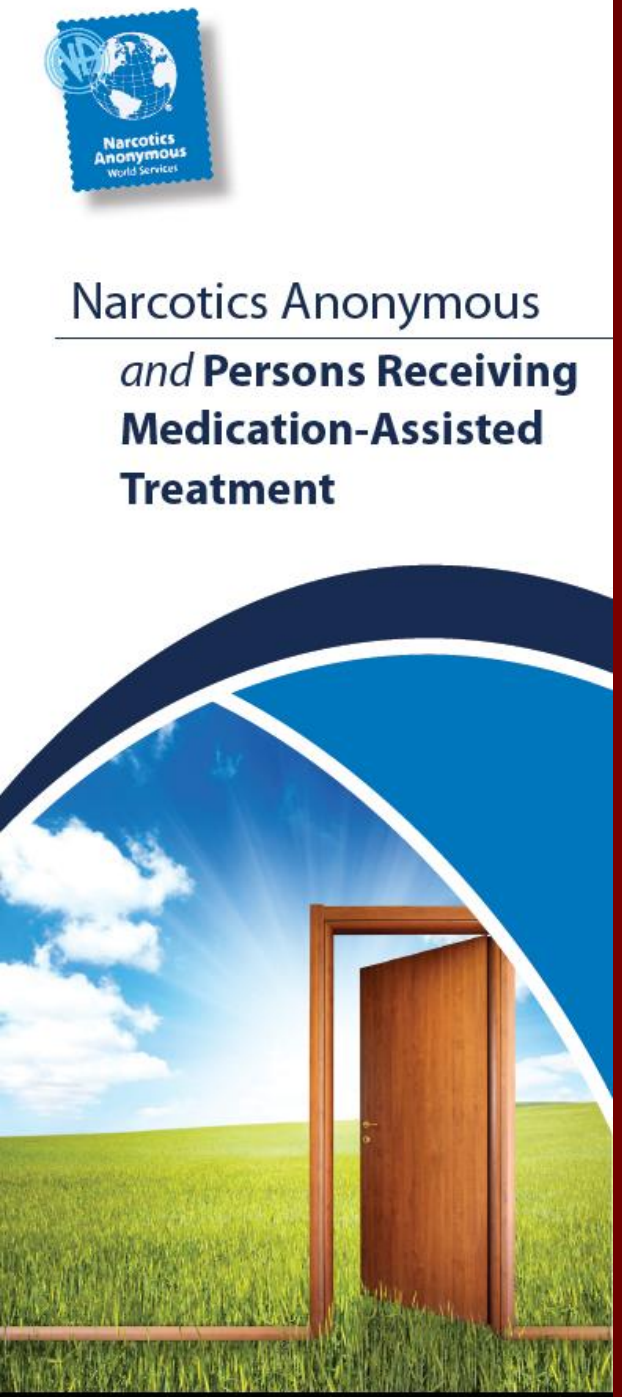
Myth #3: MAT is a bad moral choice. It is inferior to complete abstinence.

Fact: Addiction is not a moral or spiritual problem; it is a brain disease. It can be managed and treated with medication, like other medical diseases.

Myth #4: MAT is ineffective because it does not end drug dependence.

Fact: Addiction is a chronic disease like diabetes or high blood pressure. We do not ask people to stop taking insulin or blood pressure medication.

Providers Clinical Support System, 2018



THE NA PHILOSOPHY

- One source of possible criticism of MAT comes from some members of Narcotics Anonymous (NA)
  - NA's Tradition Three emphasizes "the importance of total abstinence." (NA, 2016)
  - "Those attending NA while receiving medications to treat drug addiction may be met by welcoming, accommodating members or sometimes by members who express strong opinions about medically assisted treatment." (NA pamphlet on Persons Receiving Medication-Assisted Treatment, 2016)
  - This *may* be experienced as judgment.

DEPENDENCE ≠ ADDICTION

- Addiction is compulsive drug use despite harmful consequences. It results in behaviors that damage work, social, and family obligations and connection. There are serious negative consequences to addiction. Sometimes tolerance and withdrawal symptoms occur.
- Dependence occurs when the body adapts to the drug, resulting in the development of tolerance and withdrawal symptoms.
- Physical dependence by itself does not constitute addiction.
- It is possible to become dependent on medication without becoming addicted to it. For example, a person taking steroids may become tolerant and display withdrawal symptoms, but does not mean that there are harmful consequences in other areas of their lives.

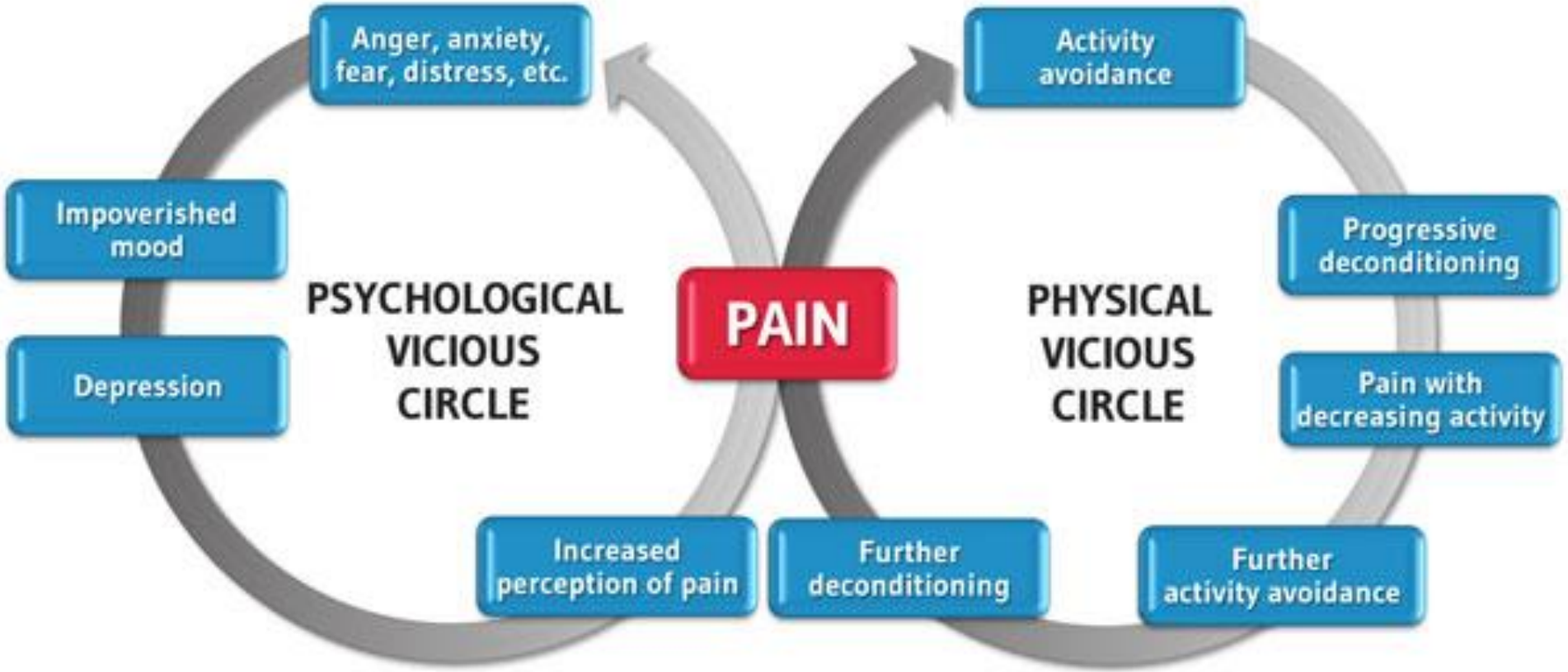
NIDA, 2018

FINAL POINTS ABOUT MAT

- In 2005, the World Health Organization added methadone and buprenorphine to its list of essential medicines
- Relapse rates for methadone (Weiss et al., 2011; Woody Et al., 2008) and buprenorphine (Magura & Rosenblum, 2001; Msson et al., 2004) are high if treatment is discontinued
  - Therefore, they probably have to be taken on a lifelong basis
  - There are no data about who may be able to successfully discontinue without relapsing
  - Clinicians must monitor them closely when tapering
    - This is especially true because their tolerance has decreased, so they are at more risk of overdosing
- Medication-Assisted Treatment means just that: Medication-*Assisted*
  - Treatment is more effective when medication is combined with therapy (NIDA, 2018)
  - Psychosocial treatment is still necessary for recovery, to build a life worth living

WHAT CAN WE DO ABOUT CHRONIC PAIN?

The Pain Cycle



NON-OPIOID PAIN MANAGEMENT STRATEGIES

- Medications
- Topical medications
- Medical options
- Physical therapies
- Psychotherapies
- Integrative health approaches

MEDICATIONS FOR PAIN

- Acetaminophen
  - Acetaminophen and NSAIDs are as effective as opioids for chronic back pain or hip or knee osteoarthritis pain (Krebs et al., 2018)
- NSAIDs
- Antidepressants
  - Tricyclic antidepressants and Venlafaxine significantly reduce neuropathic pain (Saarto & Wiffen, 2007)
- Anticonvulsants

TOPICAL MEDICATIONS FOR PAIN

- Lidocaine
- Menthol/Analgesic Cream
- Capsaicin Cream
  - For muscle and joint pain
  - For neuralgia caused by shingles
- Topical NSAIDS

THE IMPORTANCE OF TREATING SLEEP

- Pain is the #1 medical cause of insomnia
  - Of those with chronic pain, 65% have insomnia
  - People with insomnia have higher pain sensitivity (Sivertsen et al., 2015)
- Opioids cause sleep disruption (Morasco et al., 2014)
- Treat with sleep medications like Trazodone or Mirtazepine
- Treat with Cognitive-Behavioral Therapy for Insomnia (Perlis et al., 2008)

MEDICAL STRATEGIES

- Orthopedic consultation
- Prosthetic devices
- Surgery
- TENS Units
- Nerve stimulation
- Alpha-Stim
- Prolotherapy
- Interventional pain management
- Blocking or burning nerves

PHYSICAL THERAPIES

- Physical therapy
- Occupational therapy
- Hydrotherapy
- Chiropractic care
- Stretching
- Therapeutic massage
- Heat
- Cold
- Exercise for weight loss

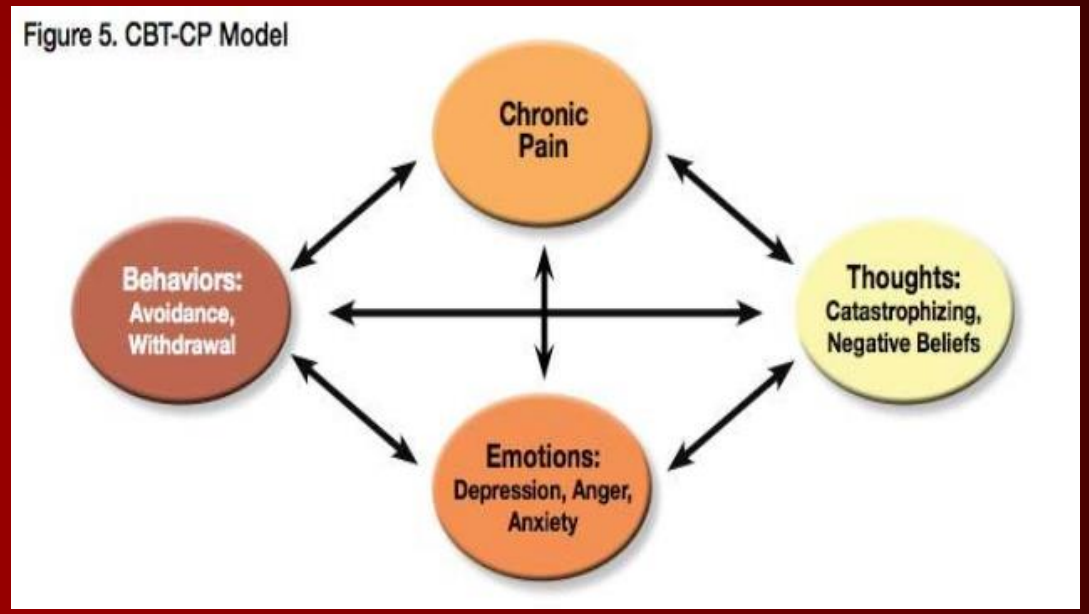
PSYCHOTHERAPY

- Cognitive-Behavioral Therapy for Pain
- Cognitive-Behavioral Therapy for Insomnia
- Eye Movement Desensitization and Reprocessing
- Psychotherapy for Co-Morbid Disorders

Experiencing Pain

CBT FOR CHRONIC PAIN

- Pain-related beliefs increase pain intensity, physical disability, and activity limitations (Gatchel et al., 2007)
- Pain catastrophizing decreases physical and psychosocial functioning (Edwards et al, 2011)
- 8-10 sessions focusing on areas such as:
  - Automatic thoughts
  - Cognitive restructuring
  - Pain beliefs
  - Progressive muscle relaxation
  - Coping self-statements



- CBT for chronic pain is effective (Ehde et al., 2014; Williams et al., 2012)

CBT FOR INSOMNIA

- Cognitive-Behavioral Therapy for Insomnia (Perlis et al., 2008)
  - Psychoeducation about sleep and what interferes with it
  - Sleep restriction
  - Stress management
  - Cognitive restructuring
  - Relapse prevention

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

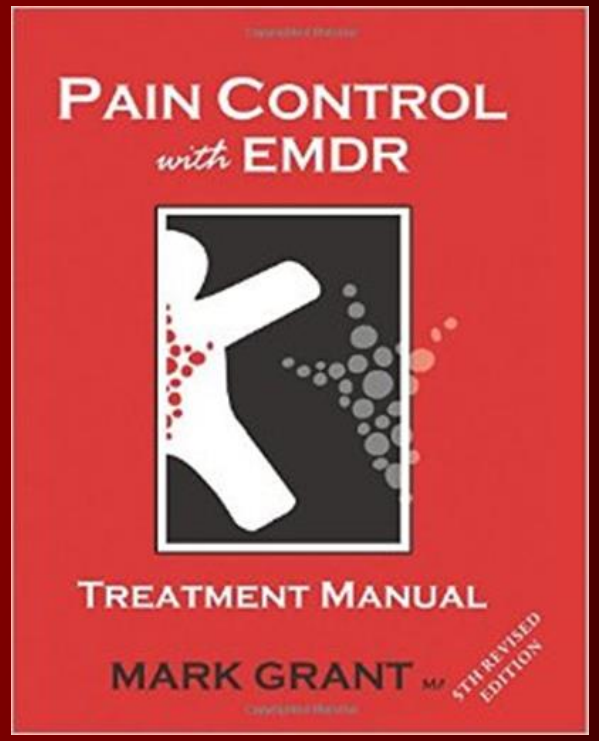
- Patient focuses on distressing image
  - States a belief that goes with it
  - Notices feelings that go with it
  - Identifies body sensations that go with it
- Therapist passes fingers back and forth, guiding the eyes
- As this occurs, the images, thoughts, feelings, and body sensations change
- Adaptive information processing results

EMDR FOR PAIN

- Pain is seen as the tip of the iceberg of a set of problems (Grant, 2015)
- Pain may be associated with a traumatic event
- Pain gets locked into the nervous system
- Bilateral stimulation brings on relaxation, which can relieve pain

EMDR FOR PAIN

- Assessment focuses on pain and trauma
- Desensitization phase focuses on pain and trauma
- EMDR can be used to treat pain (Grant, 2015)
- EMDR works for:
  - Chronic Regional Pain Syndrome
  - Phantom Limb pain (de Roos et al., 2010; Schneider et al., 2008; Wilensky, 2006)
  - Chronic Fatigue Syndrome



PSYCHOTHERAPY FOR CO-MORBID DISORDERS

- Chronic pain is often co-morbid with:
  - PTSD (Otis et al., 2003; Sharp & Harvey, 2001; Shepherd et al., 2001; Villanoe et al., 2007)
  - Anxiety (Von Korff et al., 2005)
  - Depression (Fishbain et al., 1997)
  - Substance Use Disorders (Atkinson et al., 1991; Mertens et al., 2003; Sheu et al., 2008)
- All of these require integrated or simultaneous treatment, otherwise efforts to treat the pain and/or the addiction are likely to fail

INTEGRATIVE HEALTH APPROACHES

- Mindfulness Meditation
- Yoga
- Acupuncture
- Tai Chi
- Biofeedback
- Anti-inflammatory diet

MINDFULNESS-BASED STRESS REDUCTION

- Combines mindfulness meditation and gentle yoga (Kabat-Zinn, 1990)
- Eight 2.5 hour weekly group sessions
  - Usually includes a full-day meditation retreat
- Groups of up to 25 people
- MBSR reduces chronic pain (Kabat-Zinn, 2015)

EVEN DOGS DO IT

YOGA FOR CHRONIC PAIN

- 12-week RCT, $N = 33$ (Sherman et al., 2011)
  - Yoga vs stretching vs self-care ($N = 228$) in community setting in Washington
  - Yoga significantly better than self-care at reducing pain
  - No difference w/stretching
- 8 sessions San Diego VAMC, Significant improvement (medium effect sizes) (Groessl et al., 2008)
  - Pain; energy/fatigue; depression
  - Significant correlations between number of sessions and improved outcomes
- Review article from American Pain Society & American College of Physicians found three high-quality trials on low back pain (Chou & Hoyt Huffman, 2007)
  - Reductions in functional disability, not necessarily pain
- QUERI Evidence Map of Yoga (2014) found:
  - Yoga is relatively safe
  - Yoga results in significant reductions in lower back pain and depression

DOGS DO YOGA, TOO

ACUPUNCTURE

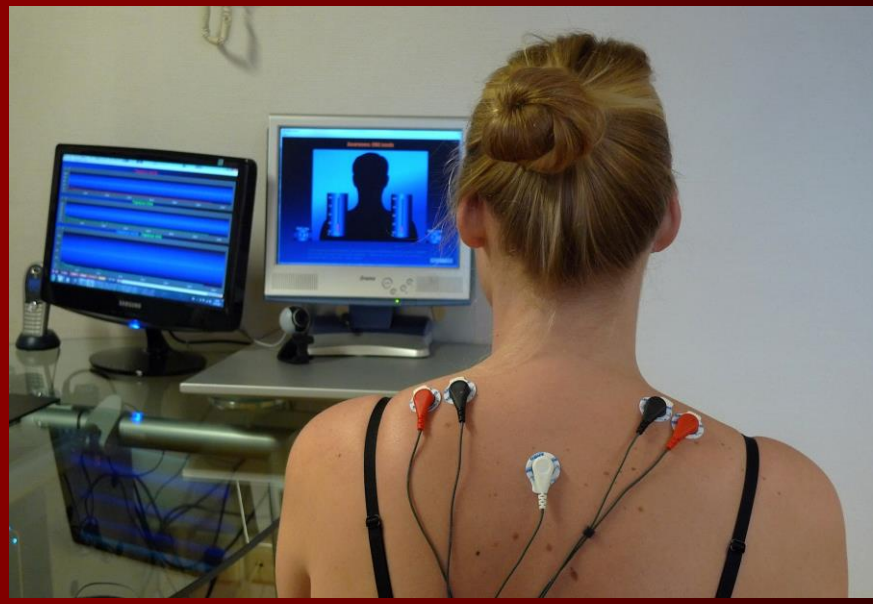
- A recent meta-analysis (Vickers et al, 2018) found that:
  - Acupuncture is effective for the treatment of chronic musculoskeletal, headache, and osteoarthritis pain
  - Treatment effects persist for over 12 months
  - These results cannot be explained by placebo effects
- It is believed to work by releasing endorphins
- Five point auricular Battlefield Acupuncture also works (Niemtzow, 2001)

TAI CHI

- Tai chi is a low-impact, slow-motion, mind-body exercise that combines breath control, meditation, and movements to stretch and strengthen muscles
- A recent meta-analysis found Tai Chi effective for osteoarthritis and chronic low back pain (Kong et al., 2016)

BIOFEEDBACK

- In biofeedback, patients learn to use their minds to control automatic body functions
- Sensors are placed on the body to monitor breathing, perspiration, skin temperature, blood pressure, and heartbeat
- These are attached to a monitoring device with flashing lights or beeps
- Biofeedback works by helping patients to relax their contracted muscles
- Biofeedback decreases low back pain for up to 8 months (Sielski, 2017)



ANTI-INFLAMMATORY DIET

Eat less

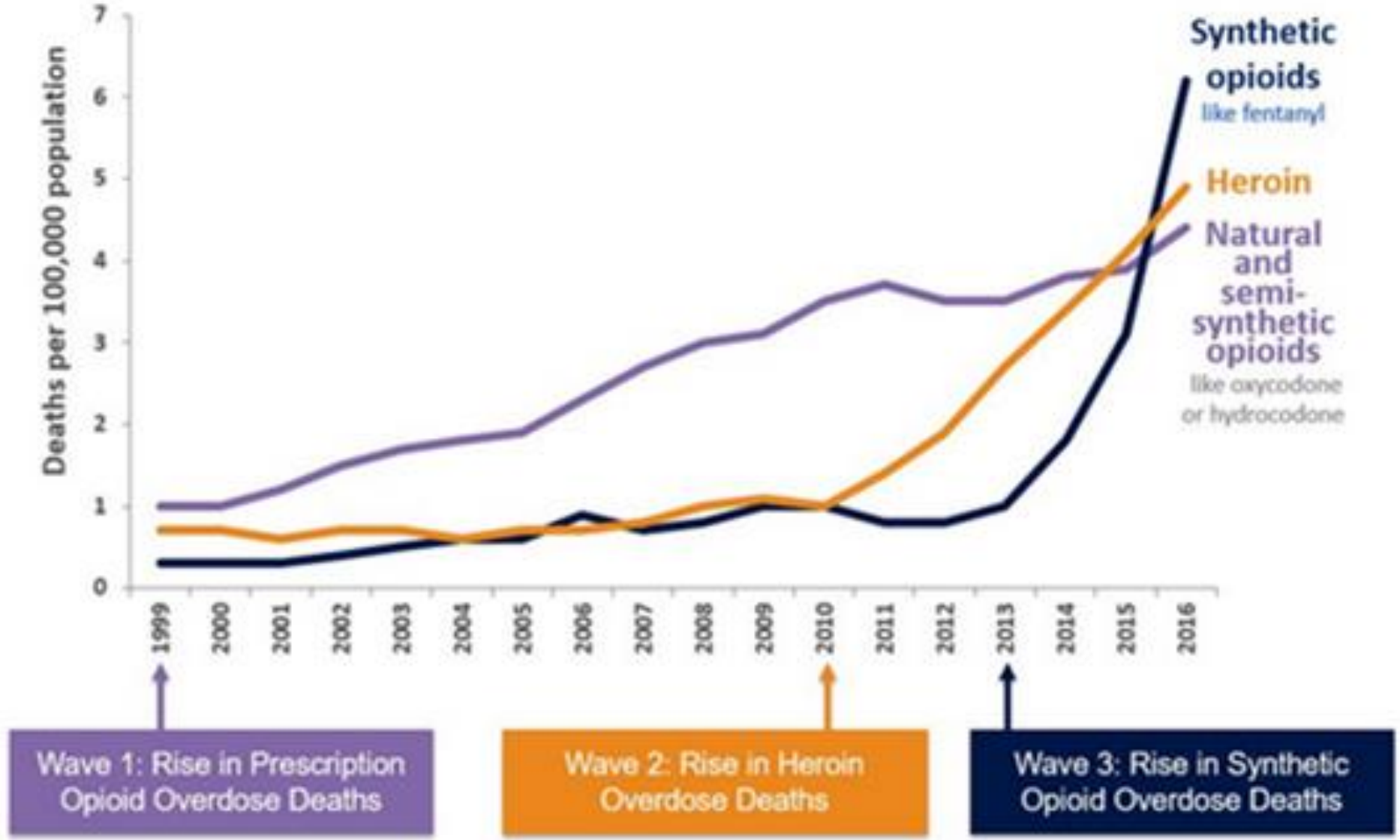
- Fats and oils
- Fried foods
- Red meats
- Sugars
- Simple carbohydrates
- These feed inflammation, which increases pain

Eat more

- Olive oil
- Cold water fish
- Leafy green vegetables
- Berries
- Complex carbohydrates
- These contain Omega 3 fats and antioxidants, which fight inflammation, thereby decreasing pain

A CONSTANTLY-CHANGING CRISIS

3 Waves of the Rise in Opioid Overdose Deaths

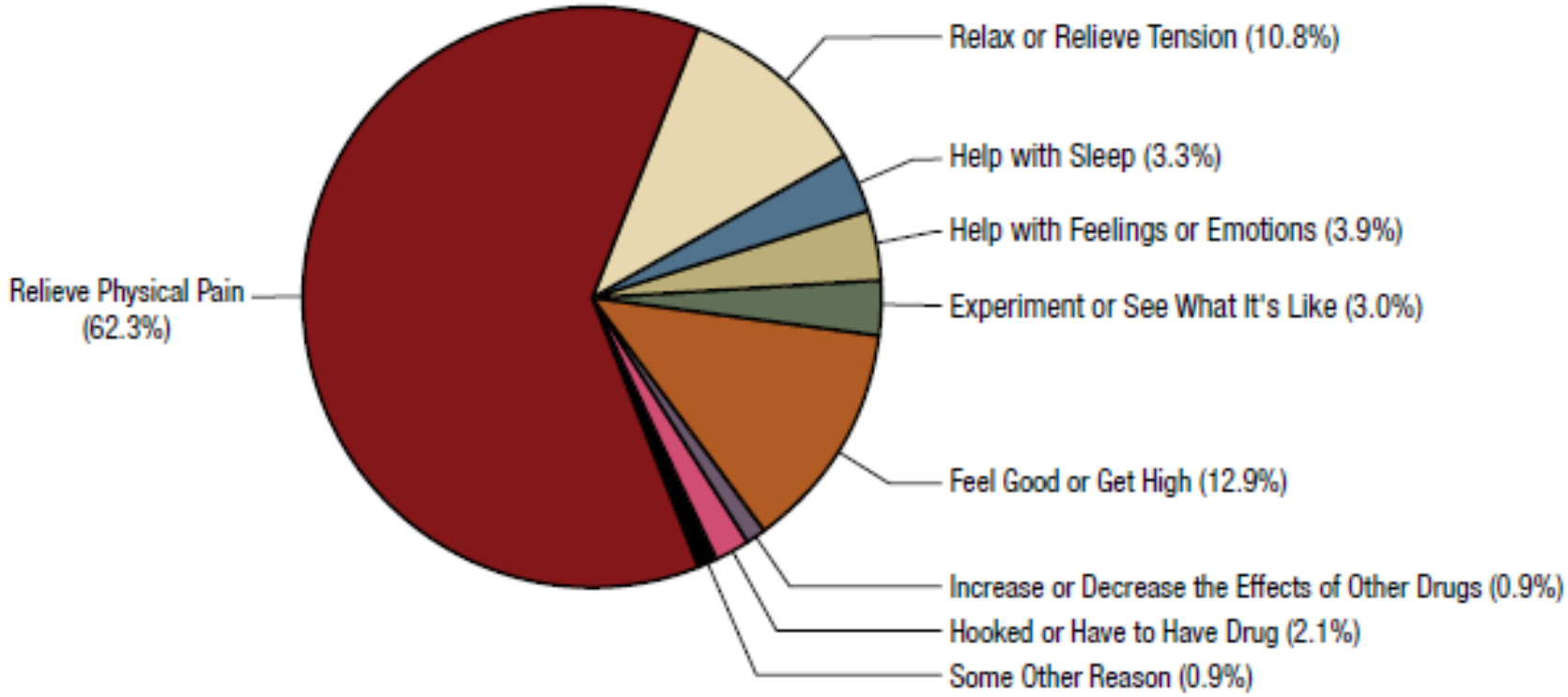


SOURCE: National Vital Statistics System Mortality File.

CDC, 2018

IT'S NOT ALWAYS ABOUT PAIN

Figure 33. Main Reason for the Most Recent Prescription Pain Reliever Misuse among People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year: Percentages, 2016



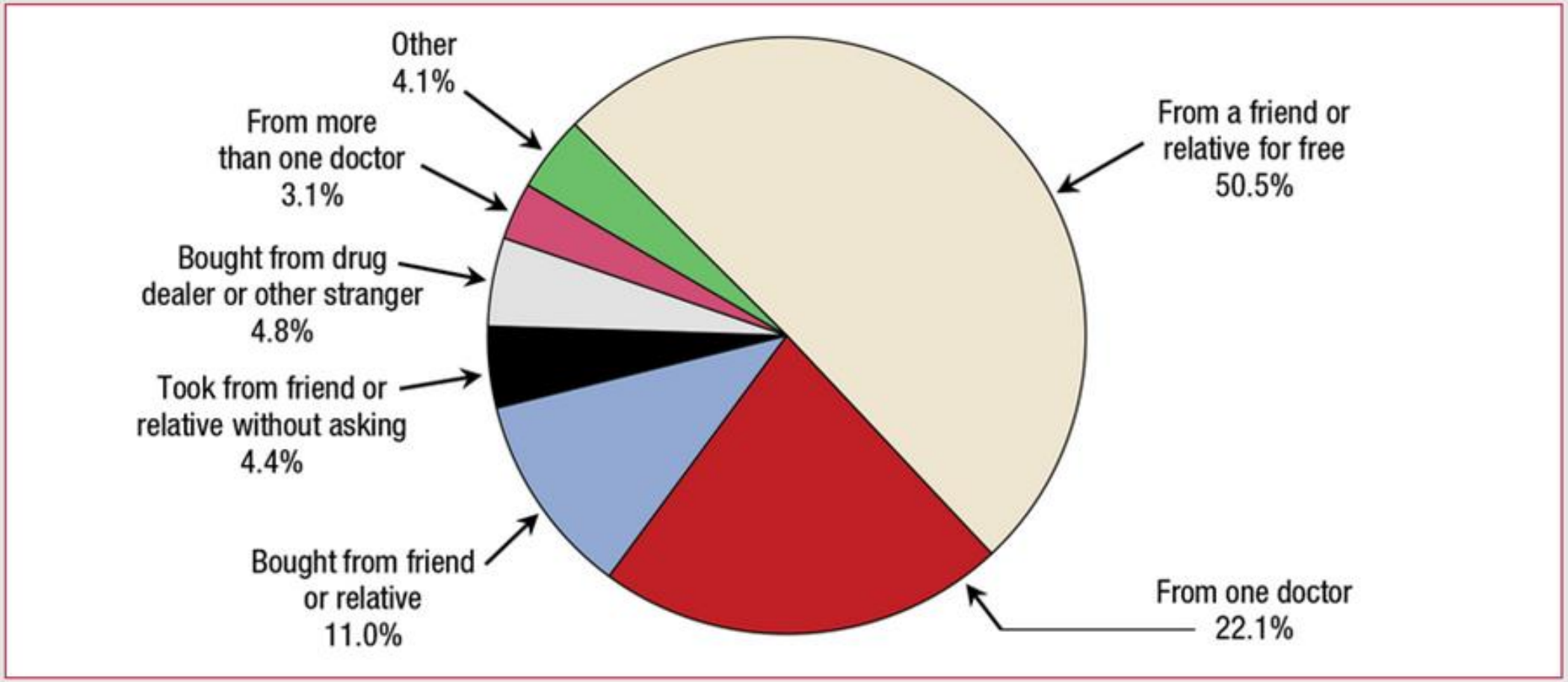
11.5 Million People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year

Note: The percentages do not add to 100 percent due to rounding.

IT DOESN'T ALWAYS BEGIN WITH PAIN

- More than 3/4 of those who misuse pain medications had already used other drugs, including benzodiazepines and inhalants, before they misused opioid pain medications (NSDUH, 2014)
- There is increasing evidence of heroin as the *first* opioid that is abused (Cicero et al., 2017)
  - In 2005, 8% of opioid initiators started with heroin
  - In 2015, 33.3% started with heroin
- Only 22.1% of opioid misusers get their pain medications from their doctors (SAMHSA, 2017)
  - They are not pain patients
  - Many of them are young

Figure 1. Source of prescription pain relievers for the most recent nonmedical use among past year users aged 12 or older: annual averages, 2013 and 2014



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2013 and 2014.

CONCLUSION

We cannot count on our presuppositions to determine who is being most affected by the opioid crisis and why. We must remain open to new data and new methods of treatment as we face an ever-changing and still-growing set of problems.

RESOURCES

SAMHSA MAT RESOURCES

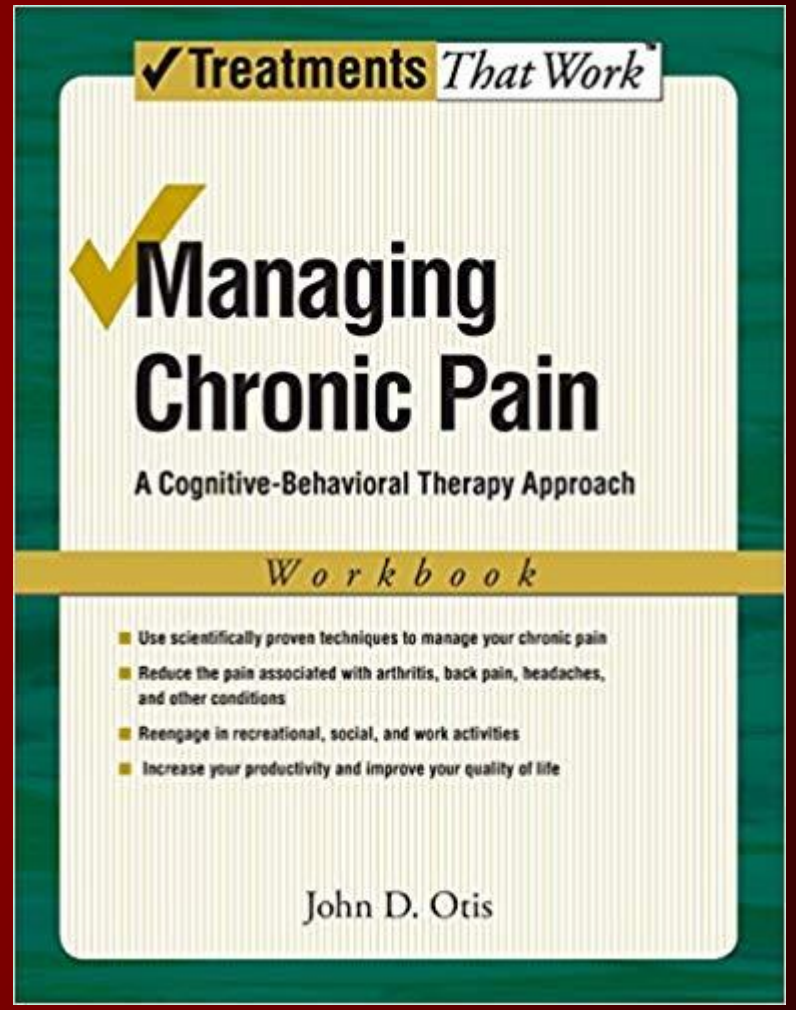
- *TIP 43: Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs: Inservice Training,* SAMHSA https://store.samhsa.gov/shin/content/SMA09-4341/SMA09-4341.pdf
- *Tip 63: Medications for Opioid Use Disorder,* SAMHSA https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document-Including-Executive-Summary-and-Parts-1-5-/SMA18-5063FULLDOC

MEDICATION-ASSISTED THERAPY

- *Medication-Assisted Treatment for Opioid Use Disorders in Drug Courts,* by Benjamin Nordstrom and Douglas Marlowe, NDCI Fact Sheet, August, 2016
- *Medication-Assisted Treatment for Opioid Use Disorder in the Justice System,* AATOD Fact Sheet, October, 2017
- *Adult Drug Courts and Medication-Assisted Treatment for Opioid Dependence,* SAMHSA In Brief, Summer, 2014
- *Treating Comorbid Opioid Use Disorder in Chronic Pain,* by Annette Matthews and Jonathan Fellers, eds.

CBT FOR CHRONIC PAIN

- Managing Chronic Pain: A Cognitive-Behavioral Approach Therapist Guide by John Otis
- Managing Chronic Pain: A Cognitive-Behavioral Approach Workbook by John Otis
- Free manual at https://www.va.gov/painmanagement/docs/cbt-cp_therapist_manual.pdf
- Free online CBT-CP program at http://www.cbt.drwilderman.com/



COGNITIVE-BEHAVIORAL THERAPY FOR INSOMNIA

- *Cognitive Behavioral Treatment of Insomnia: A Session-by-Session Guide* (2008), by Michael L. Perlis, Carla Jungquist, Michael T. Smith, and Donn Posner
- *Overcoming Insomnia: A Cognitive-Behavioral Therapy Approach Workbook* (2008), Jack Edinger and Colleen Carney

EMDR

- *Eye Movement Desensitization and Reprocessing (EMDR): Basic Principles, Protocols, and Procedures, 3rd ed.* (2017), Francine Shapiro
- *EMDR: The Breakthrough Therapy for Overcoming Anxiety, Stress, and Trauma* (2016), Francine Shapiro and Margot Silk Forrest
- *Pain Control with EMDR: Treatment Manual, 5th ed.* (2015), Mark Grant
- www.emdr.com
- www.emdria.org
- www.emdrhap.org

MBSR BOOKS

- *Full Catastrophe Living, 2nd ed.*(2013), Jon Kabat-Zinn
- *Mindfulness for Beginners: Reclaiming the Present Moment - and Your Life (*2011), Jon Kabat-Zinn
- *A Mindfulness-Based Stress Reduction Workbook* (2010), Bob Stahl, Elisha Goldstein, Saki Santorelli and Jon Kabat-Zinn
- *The MBSR Home Study Course* (2016), Saki Santorelli and Florence Meleo-Meyer

MINDFULNESS MEDITATION CDS

- *Mindfulness Meditation for Pain Relief: Guided Practices for Reclaiming Your Body and Your Life,* John Kabat-Zinn

ONLINE MBSR COURSES

- Free online MBSR course: http://palousemindfulness.com/selfguidedMBSR.html
- Online video course: http://www.soundstrue.com/store/the-mbsr-online-course-3226.html

ONLINE GUIDED MINDFULNESS MEDITATIONS

- http://www.va.gov/PATIENTCENTEREDCARE/resources/multimedia/index.asp
- https://med.virginia.edu/mindfulness-center/
- http://www.fammed.wisc.edu/mindfulness-meditation-podcast-series/
- http://health.ucsd.edu/specialtes/mindfulness/programs/mbsr/Pages/audio.aspx
- http://marc.ucla.edu/body.cfm?id=22

APPS

- Stop, Breathe, and Think

- Mindfulness Coach

- CBT for Insomnia

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