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UHN Centre for Mental Health

THE OVERLAP WITH CHRONIC PAIN AND MENTAL HEALTH PHARMACOLOGY

Staff Anesthesiologist / TGH

Director, Pain Services

Director, Transitional Pain Program

GoodHope Ehlers Danlos Syndrome Chair in Translational Medicine

Director, GoodHope Ehlers Danlos Syndrome Clinic

University Health Network

President, Canadian Pain Society

President, Canadian Consortium for the Investigation of Cannabinoids

CIHR Chair, Chronic Pain, Mental Health & Substance Use

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Twitter Handle: @Drhaclarke

RESEARCH AT UHN

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Presenter Disclosure

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  - **Patents: n/a**
  - **Other: Managing Life**

Mitigating Potential Bias

- No content in this presentation relates to the previous disclosures

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Outline

1. What is Pain and the current landscape in Canada

2. Understand the overlap in the use of medications for these co-morbid conditions

3. Provide some pearls and help avoid pitfalls when prescribing medications to the chronic pain patient

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Mechanism of Normal Pain

Pain is the interpretation of what you feel after:

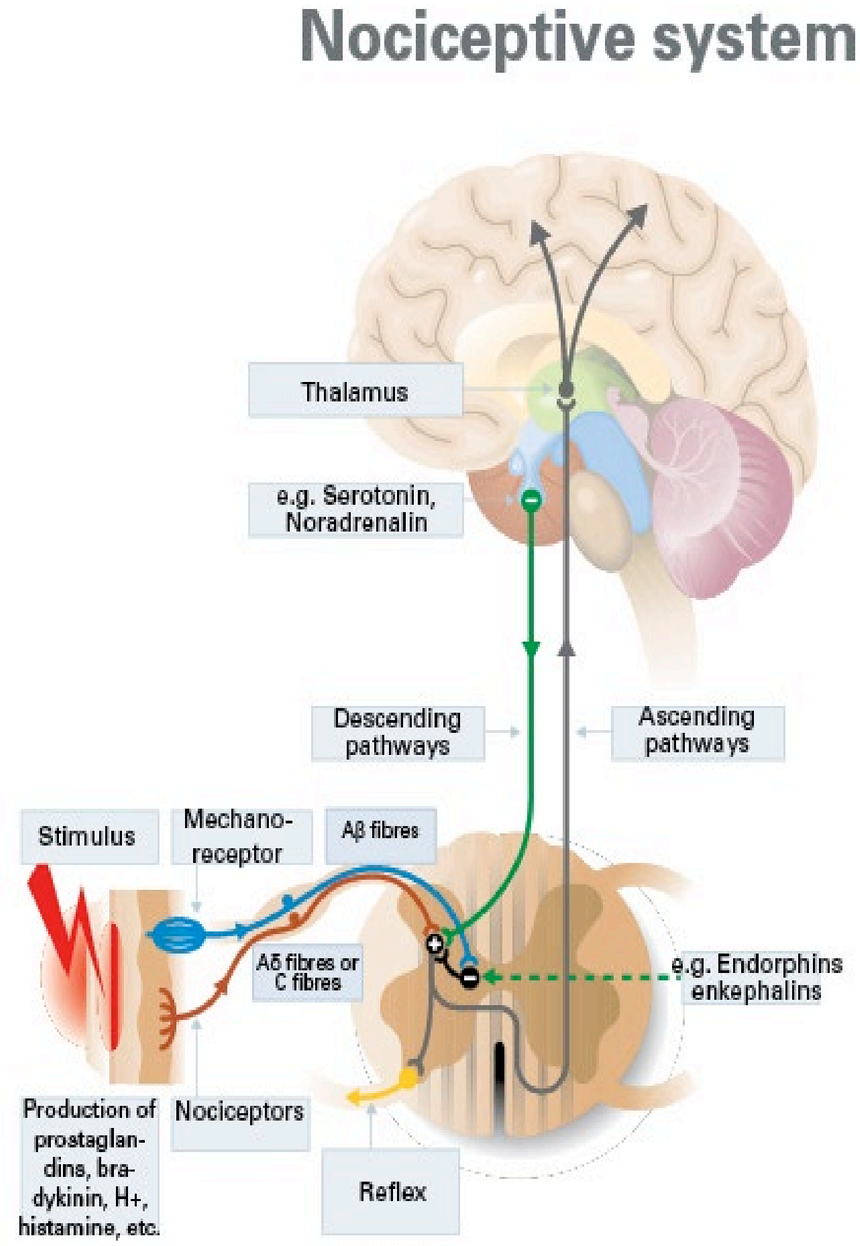
Up (transmission)

&

Down (modulation)

&

“Processing”



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Credit: Dr. Andrew Smith

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The Experience of Pain

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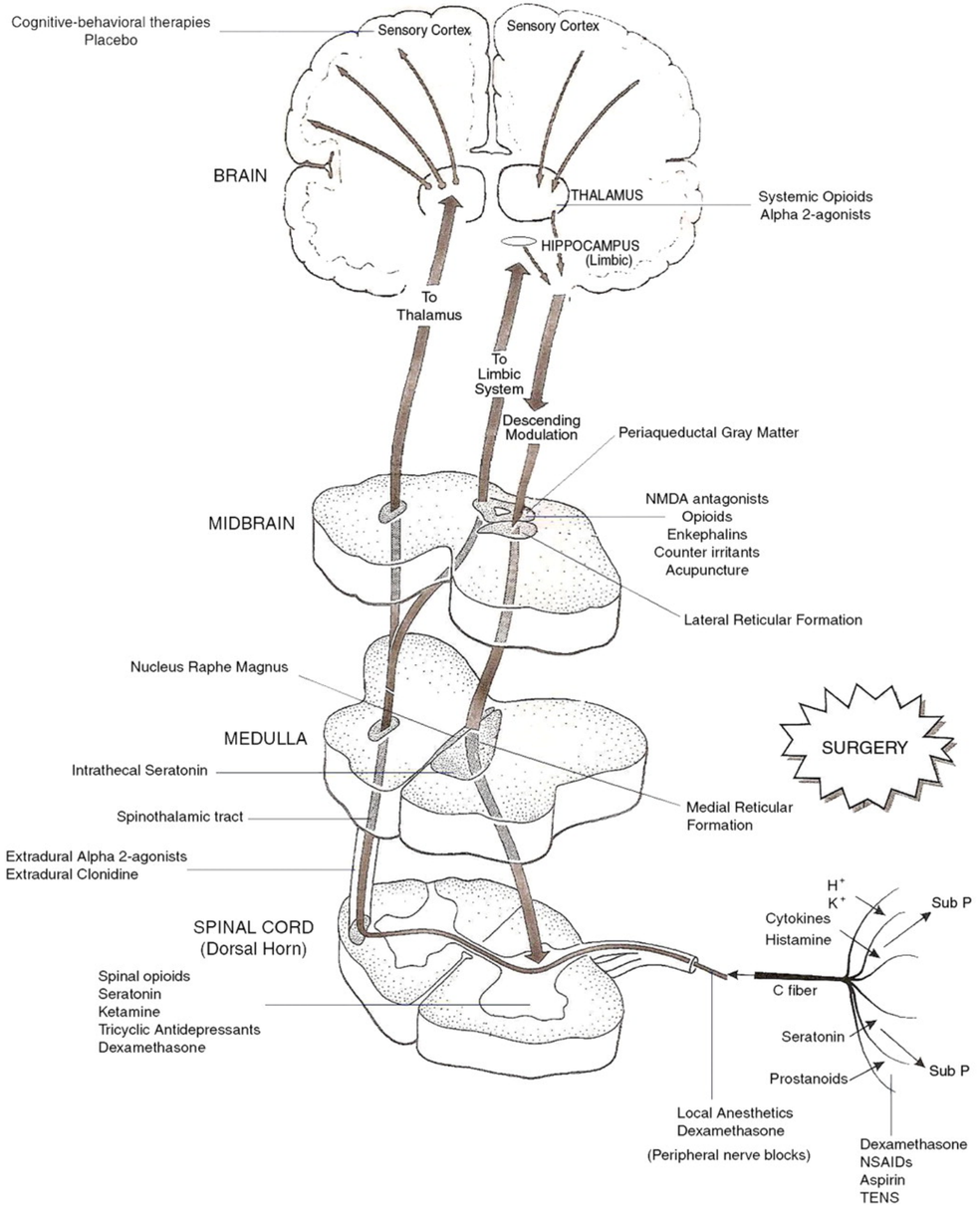
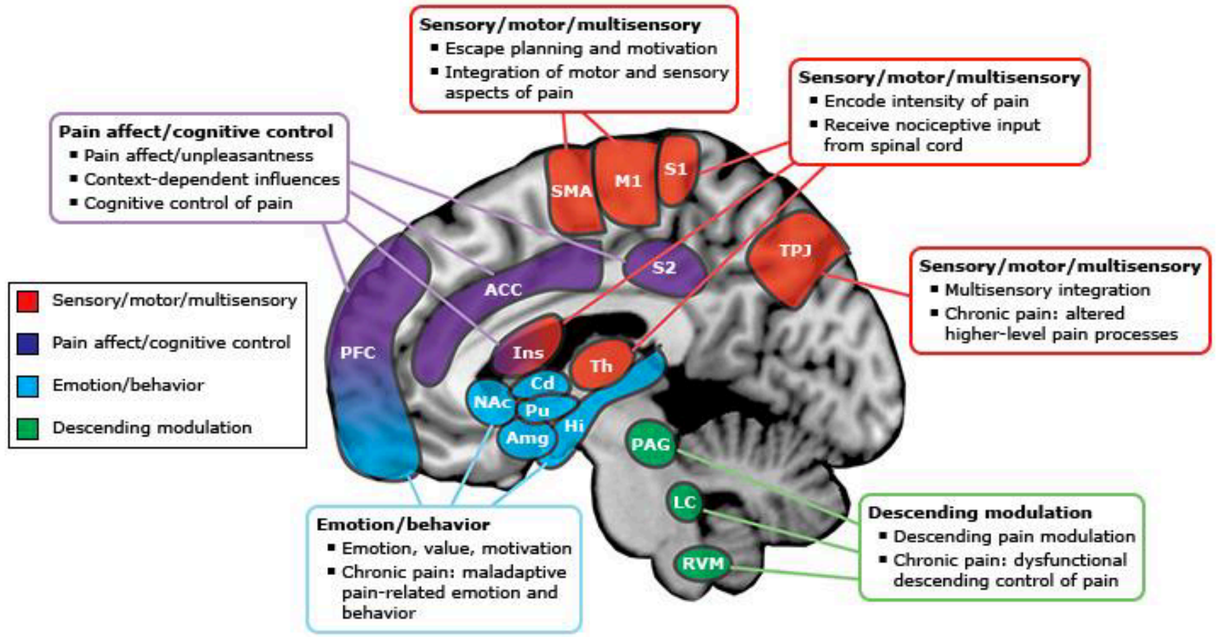
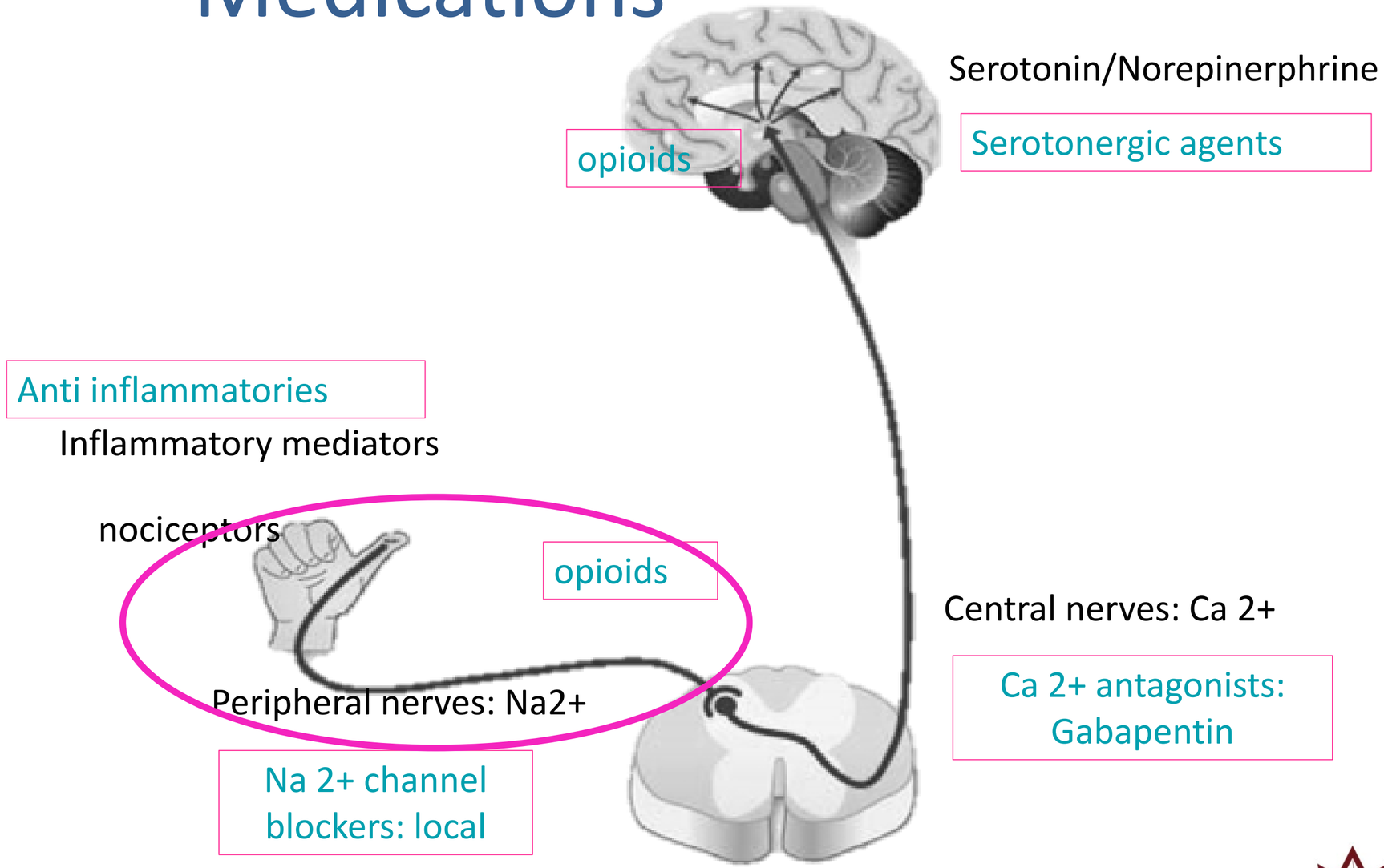


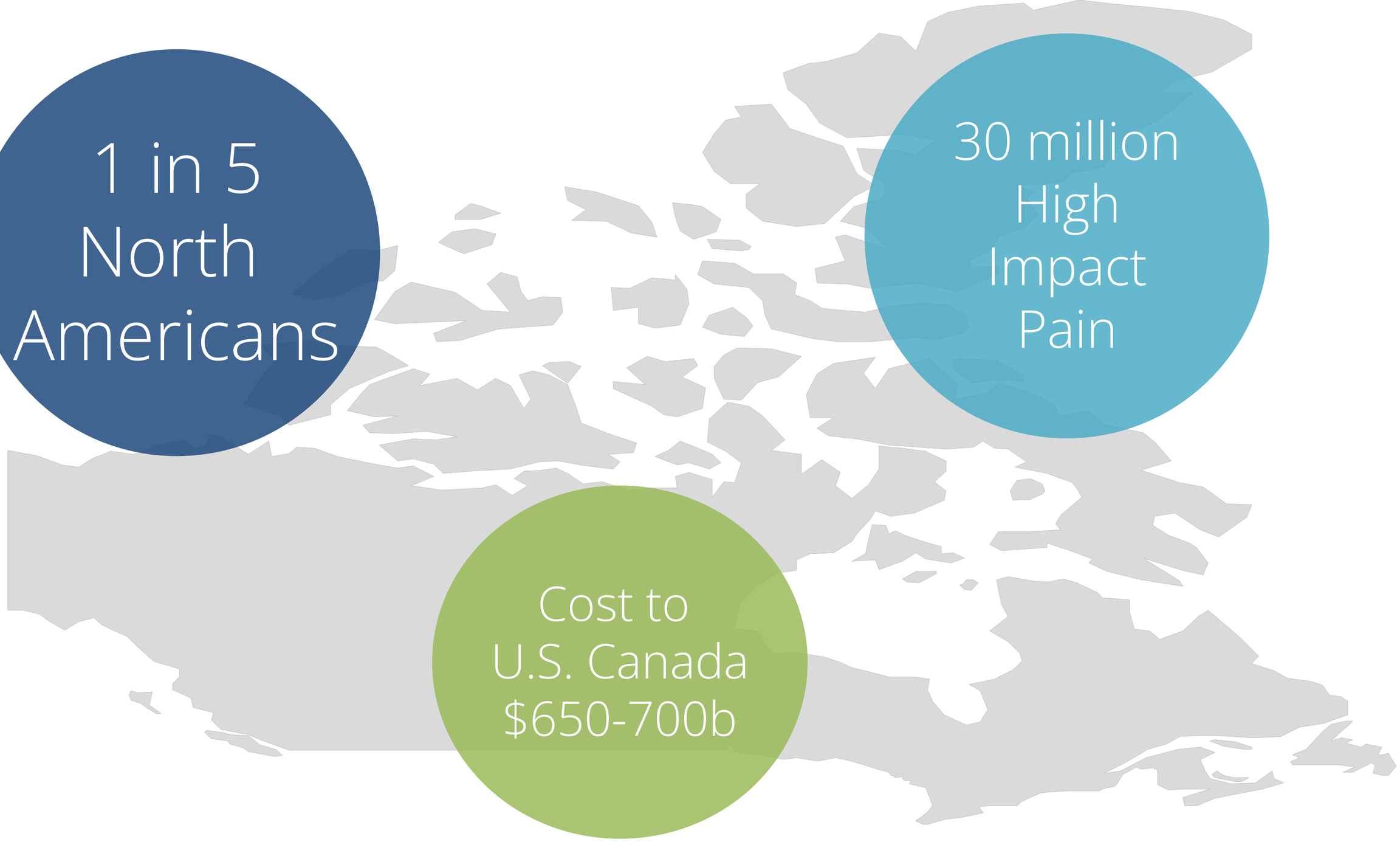


1. Transduction
2. Transmission
3. Modulation
4. Perception

Credit: Dr. Andrew Smith

Medications





Source: Canadian Pain Task Force, CDC

The Burden of Pain in Canada

- Pain affects 1 in 5 Canadians (20%)
  - 7.6M Canadians suffer from chronic pain
  - Disproportionately affects minoritized population
  - Affects quality of life, ability to work and support networks
- Pain cost Canadians upwards of$40.3B in 2019
  - Represents **the largest** health-related cost in Canada
- Effective management is limited by our poor understanding of pain mechanisms

Health Canada Santé Canada

Canada

Canadian Pain Task Force,

The Burden of Pain in Canada

•Pain is the number one driver of disability in Canada

• The most common types of disabilities for adults aged 25 to 64 years were pain related (63%), mental health (46%), and flexibility (36%)

• For seniors (65 years or older), pain -related (68%), mobility (63%) and flexibility (59%) we the most common types of disabilities

• Pain is implicated as the culprit for the opioid crisis (i.e. oxycodone / oxycontin)

• Pain is a significant driver of Inequity in Health Care and Society

Further Current Facts

Budget 2023

- **$192B over 10 years** in health transfers to PTs, including $25B to support common health priorities
- $2B over 10 years toward the Indigenous Health Equity Fund
- $359.2M towards the Canadian Drugs and Substances Strategy (incl. $144M to SUAP)

Budget 2024

- $6.1B over six years for a new Canada Disability Benefit
- $562.5M in 2024-25 towards the Non-Insured Health Benefits Program for First Nations and Inuit populations
- $630.2M to support Indigenous people’s access to mental health services
- $1.8 billion over five years (with $748.3 million per year ongoing) to the federal research granting agencies

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Acute vs Chronic pain

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- Acute pain is a vital, protective mechanism that permits us to live surrounded by potential danger
- Chronic pain is not helpful and is a **chronic disease condition** (like diabetes, HBP)
- Chronic pain persists after the normal expected duration of healing (3-6months) and is a brain signal problem, like an alarm that is stuck on
- Senitization: peripheral; central (spinal, including glial cell component; brain – neuroplasticity with cortical reorganization)
- Surgery and opioids don't work well (medications in general may provide <20% of the overall improvement)
- The internal "harm alarm" is stuck in the "on" posit

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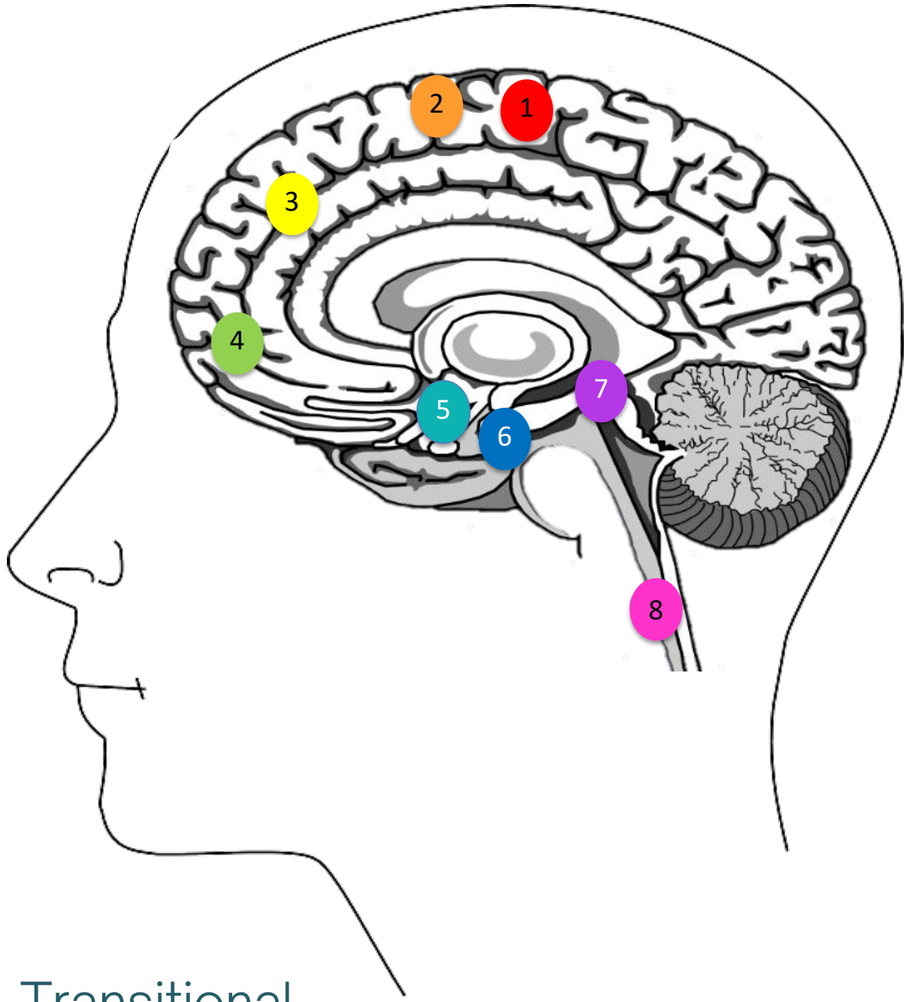
The Brain- Pain Perception



1	Sensory Cortex	Identifies body parts	Physiotherapy
2	Premotor/ motor cortex	Organizes movements	Physiotherapy
3	Cingulate cortex	Concentration and focus	OT
4	Prefrontal cortex	Problem solving	OT
5	Hypothalamus/ thalamus	Stress response, regulates autonomic system	Psychologist
6	Amygdala	Fear, anxiety, anticipation, emotions	Psychologist
7	Hippocampus	Memory	
8	Brain stem	Passes messages between the brain and the rest of the body	

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Journal of Pain Research

Dovepress
open access to scientific and medical research

Open Access Full Text Article

PERSPECTIVES

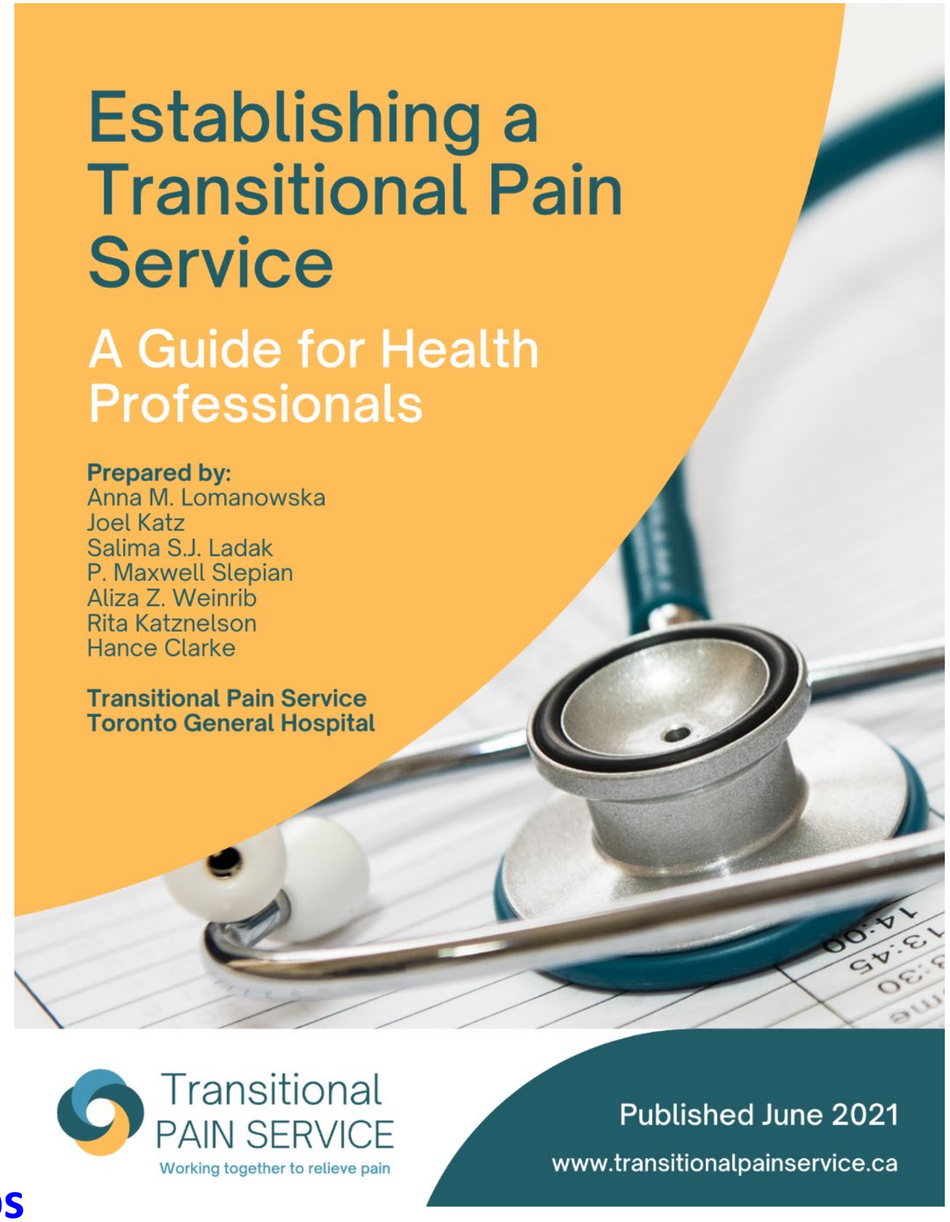
The Toronto General Hospital Transitional Pain Service: development and implementation of a multidisciplinary program to prevent chronic postsurgical pain

Katz, Weinrib et al. J Pain Res 2015:8;695-702

Download our TPS How-To Guide

How-To Guide contains:

- an overview of the TPS approach to patient care
- guidelines regarding assessment of risk factors for Chronic Post-Surgical Pain (CPSP)
- medication management recommendations
- details regarding referral, patient flow, and clinic administration
- information regarding patient evaluation questionnaires and eHealth tools for patients
- details regarding our pain care services including medical and nursing care, psychology, and physiotherapy
- insights regarding the benefits of establishing a TPS and potential challenges when setting up a TPS clinic
- and more!

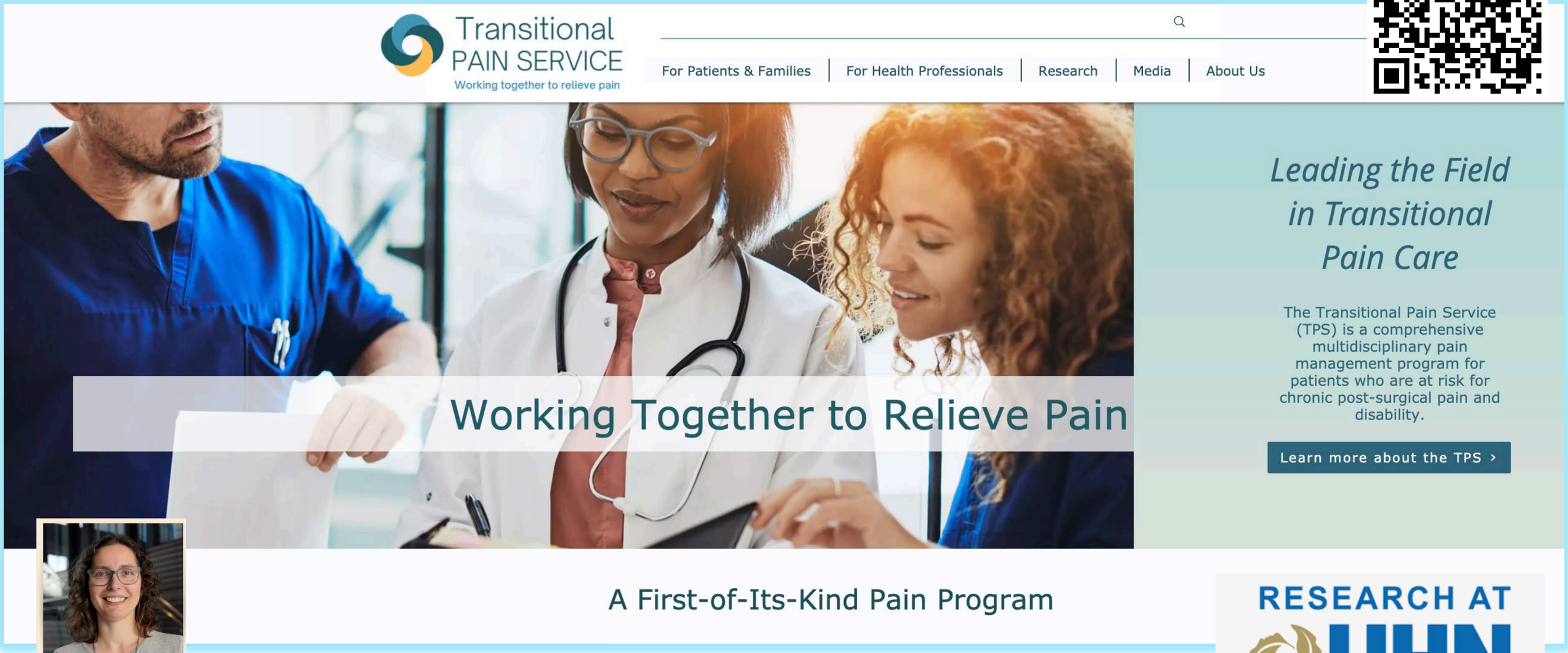


Use QR code or Go to: www.transitionalpainservice.ca/establish-tps

Health Canada Santé Canada

Funded by Health Canada Grant

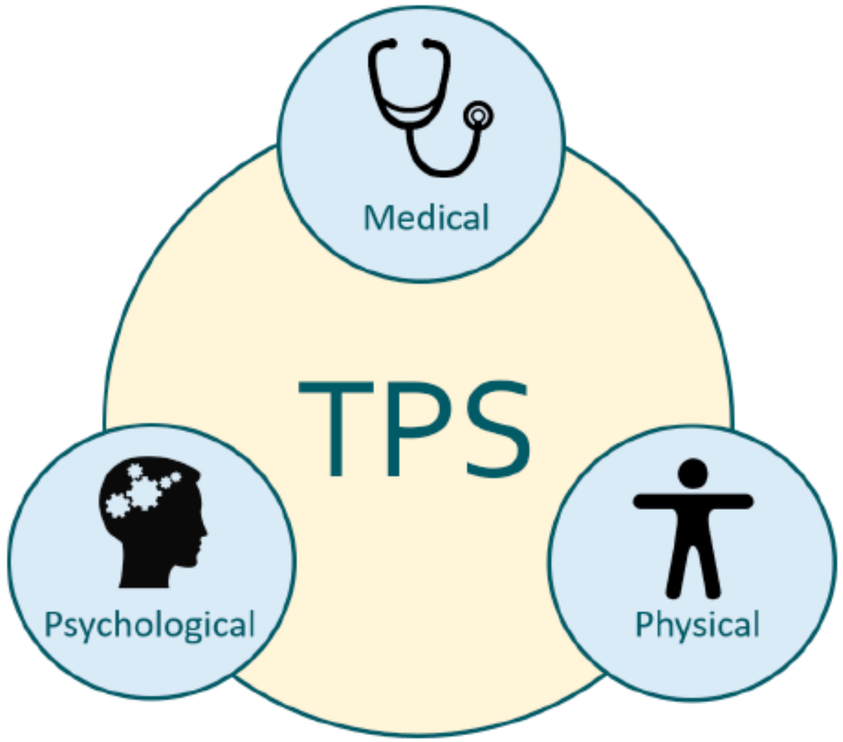
www.transitionalpainservice.ca

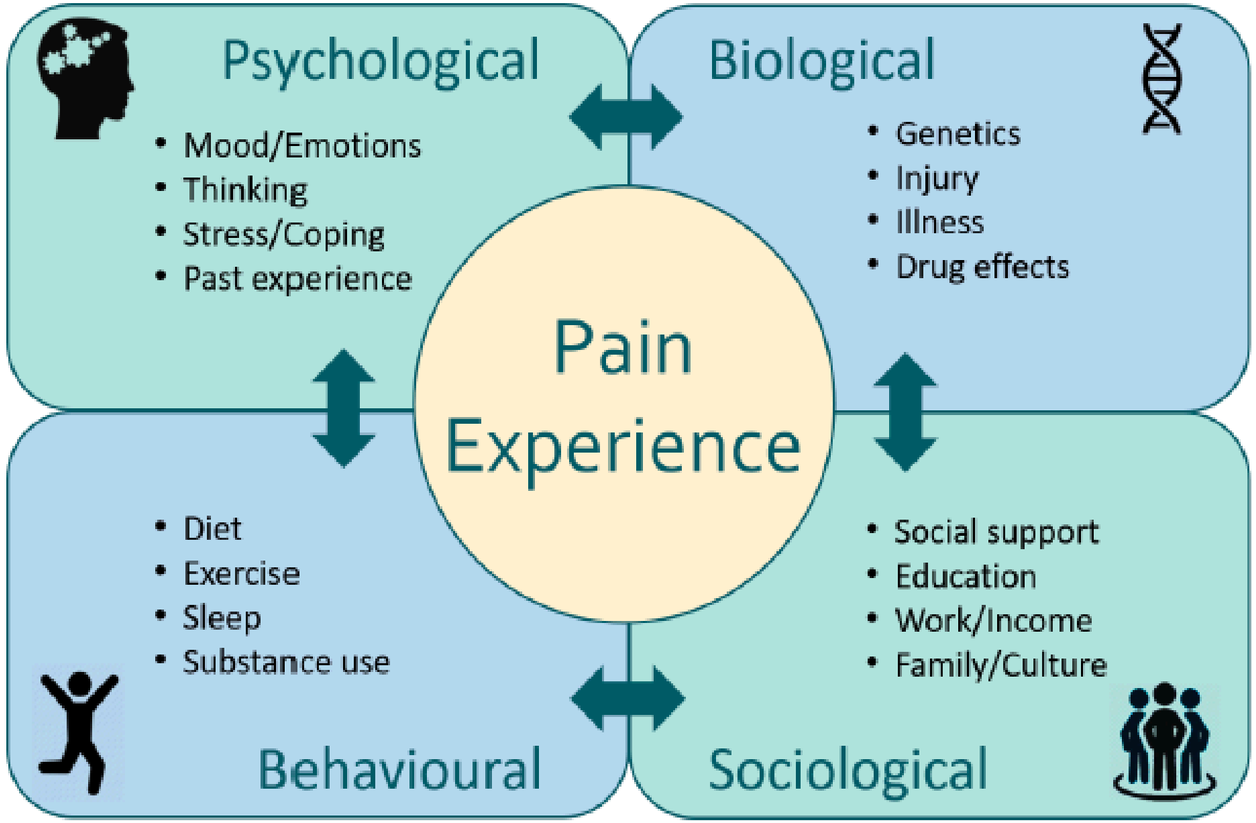


Anna Lomanowska
PhD

RESEARCH AT UHN

Triad of Pain Treatment





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https://www.transitionalpainservice.ca/establish-tps

Shifting The Focus to Patient Education

www.transitionalpainservice.ca/learn

Online Learning Modules Designed for Our Patients

The Transitional Pain Service has developed specialized learning modules to better prepare our patients for treatment at the clinic.

Research studies show that learning more about how pain works helps people better cope and manage their own pain. If you're a person in pain, or you are supporting someone who has ongoing pain, we hope that these resources will be a helpful companion to treatment.

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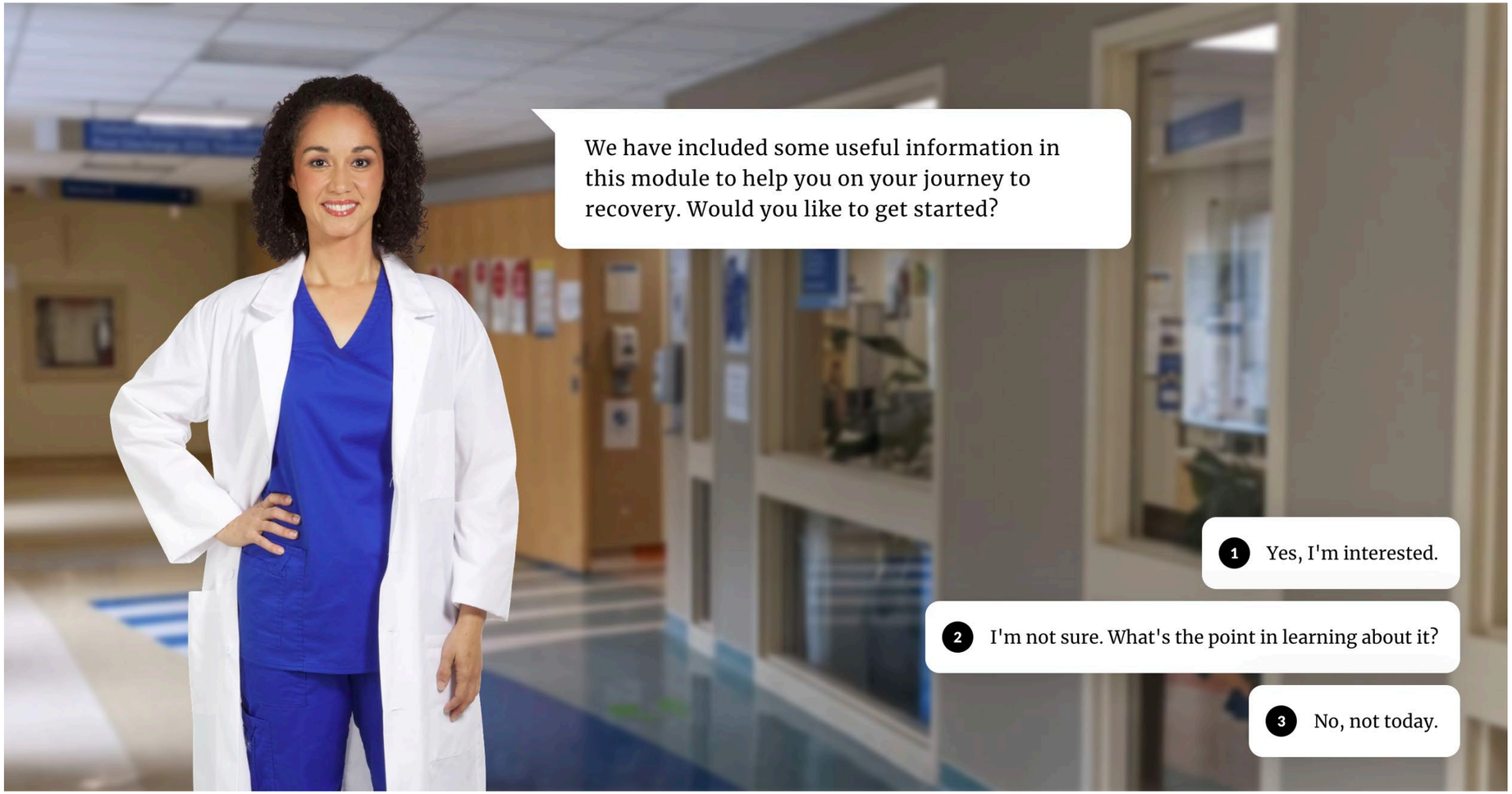
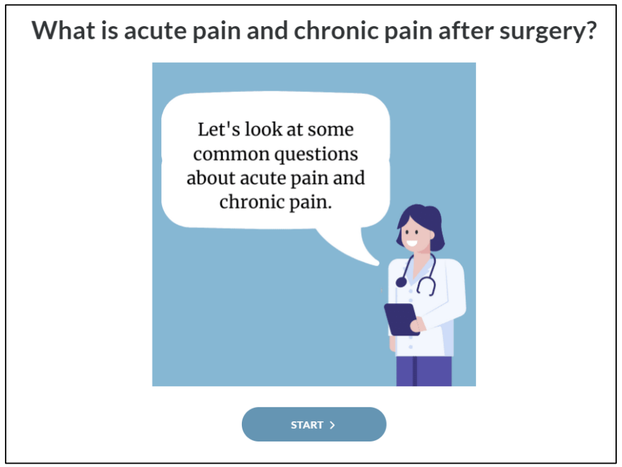
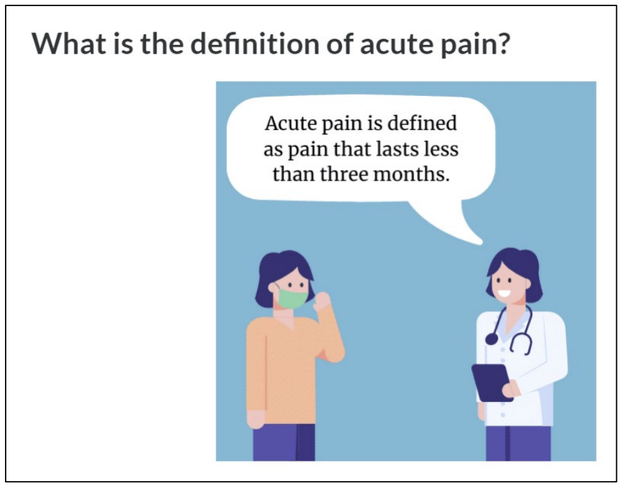
Module on Chronic Post-Surgical Pain

https://www.transitionalpainservice.ca/learn







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Module on Psychology Treatment for Pain

https://www.transitionalpainservice.ca/learn

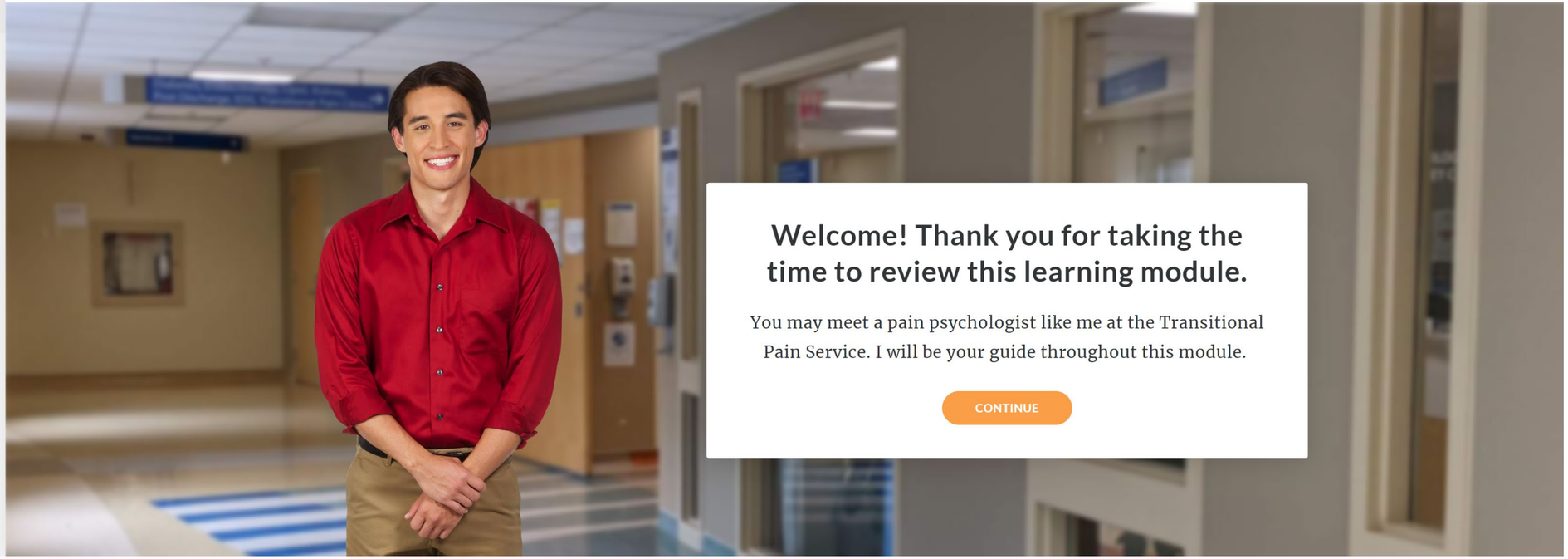
Psychology and the Treatment of Chronic Post-Surgical Pain

0% COMPLETE

- 1.1 The Pain Treatment Approach at the Transitional Pain Service
- 1.2 The Psychology of Pain
- 2.1 Psychology Treatment Strategies
- 2.2 A Typical Timeline of Psychology Treatment
- 2.3 Let's Review!
- 3.1 Psychology Treatment Companion Tools and Resources

MODULE: Lesson 1 of 6

1.1 The Pain Treatment Approach at the Transitional Pain Service



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In Development: Self-Guided Online Psychology Program

Kindness and Compassion Excercise

A little kindness can go a long way to ease suffering when living with chronic pain.

This is a mindfulness exercise called the “Kindness and Compassion Meditation”. It was first developed by leading mindfulness scholar, Jon Kabat-Zinn.

When you click “Play” below, you will hear guided instructions that will take you through the exercise step by step. Before starting, make sure that you’re in a private and quiet space where you won’t be interrupted.

Please click “Play” when you're ready. You can also read along with the audio using the transcript below.

0:00 6:45

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Pain Canada

Our national action network

Managing Pain Before and After Surgery: A course for people undergoing surgery

This is a free self-paced online program designed to help people undergoing surgery and their families better manage pain after surgery and decrease complications.

1:30–2 hours

Available for all Canadians

https://www.paincanada.ca/course/managing

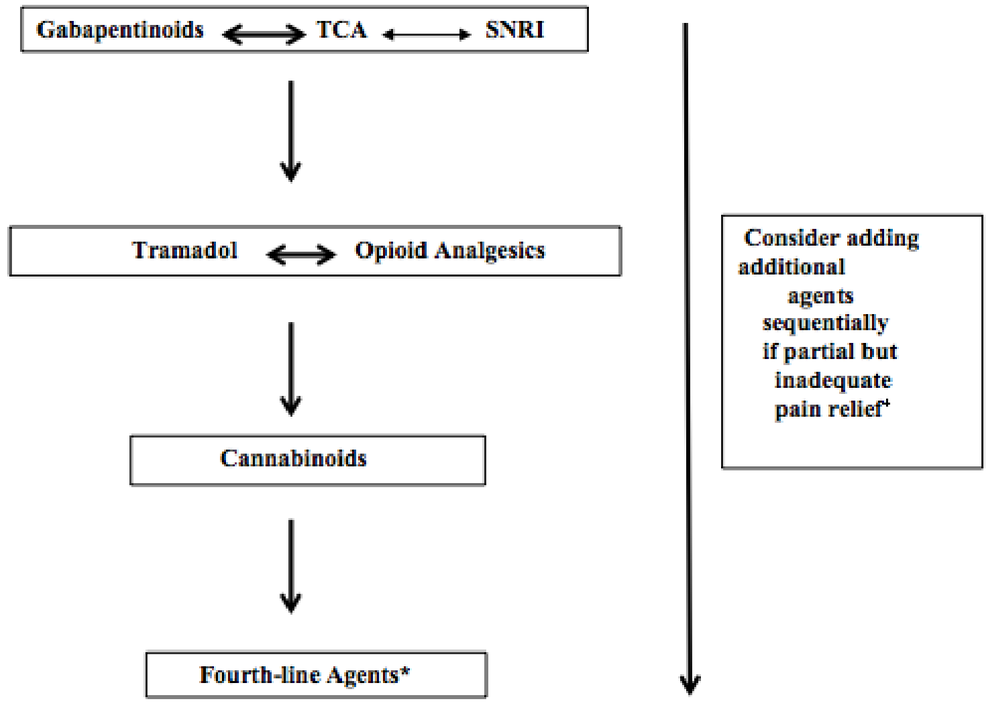
Common Mental Health Comorbidities

- Anxiety
- Depression
- Catastrophizing
- Use Disorders

Treating comorbid psychological illnesses such as anxiety and depression will have a positive effect on pain, and on the patient's ability to manage their pain and reduce opioid consumption

Sutherland et al., Progress in Neurpharm 2018

Chronic Neuropathic Pain Guidelines



Algorithm for the pharmacological management of neuropathic pain

*topical lidocaine(second-line for postherpetic neuralgia), methadone, lamotrigine, lacosamide, tapentadol, botulinum toxin

+ limited randomized controlled trial evidence to support add-on combination therapy

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Moulin, Boulanger, Clark, Clarke, Dao, Finley et al., Pain Res. & Management Dec, 2014

Tricyclic Antidepressants

- Amitriptyline / Nortriptyline (active metabolite) (25 – 150 mg/d)

TCAs have been shown in small studies to be effective in the treatment of painful diabetic neuropathy (PDN), post-herpetic neuralgia (PHN) and central pain.

- *NNT of 5.1 Based on Cochrane Data*

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Mico et al., 2006; Perahia et al., 2006

Tricyclic Antidepressants

Fallen out of favour in mood disdorders:

- *anticholinergic adverse effects*
- *adverse cardiac effects (prolonged PR, QRS and QT intervals as well as orthostatic hypotension)*
- *Effect take weeks re: mood*

- *Attenuation of allodynia and hyperalgesia is typically achieved more rapidly*

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Pacher and Kecskemeti, 2004

Serotonin and Norepinephrine Reuptake inhibitors

- Indicated for both Major Depressive Disorder and Anxiety
- Multiple trials demonstrating the efficacy in pain

Duloxetine: strongest evidence is in treating Peripheral Diabetic Neuropathy, fibromyalgia and osteoarthritis.

- NNT for a 50% pain reduction in fibromyalgia is 8.

Moulin et al. 2014, *Lunn et al., 2014*

Comparing Doses for Pain vs Depression

Table 1
Dosing of antidepressant medications for depression and pain.

Medications	Antidepressant dose	Pain dose
Amitriptyline	100–300 mg daily	25–150 mg daily
Nortriptyline	75–150 mg daily	25–150 mg daily
Duloxetine	60–120 mg daily	60 mg daily
Venlafaxine	75–225 mg daily	37.5–225 mg daily
Desvenlafaxine	50–100 mg daily	200–400 mg daily

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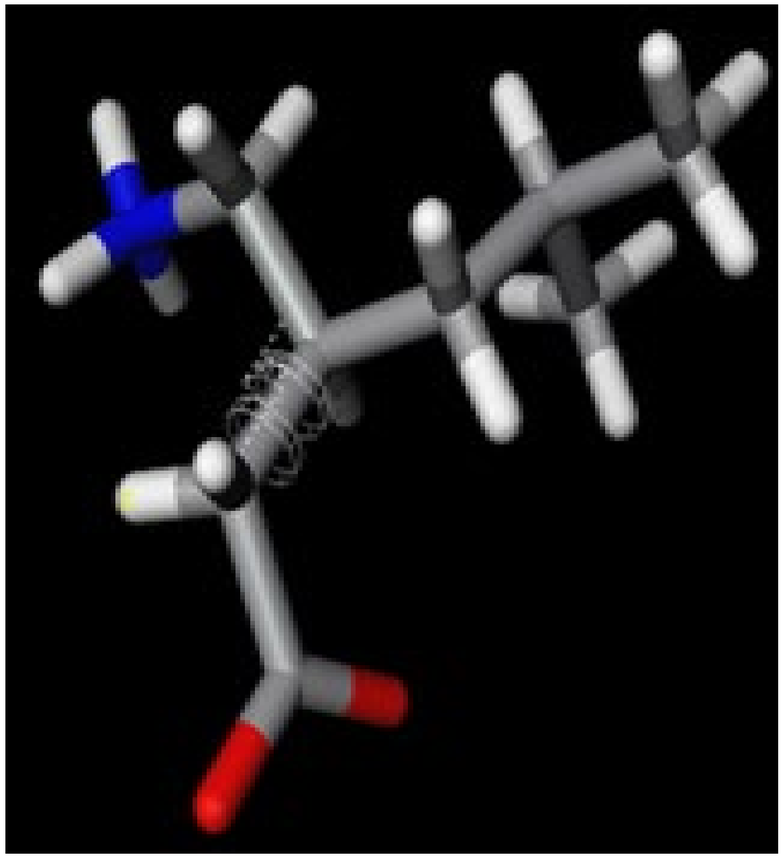
Sutherland et al., Progress in Neurpharm 2018

Anticonvulsants: Gabapentin and Pregabalin

- Anticonvulsants
- Analgesic
- Alpha 2 delta Ca Channel blocker
- Amino Acid substitution more reliable absorption profile than gabapentin.



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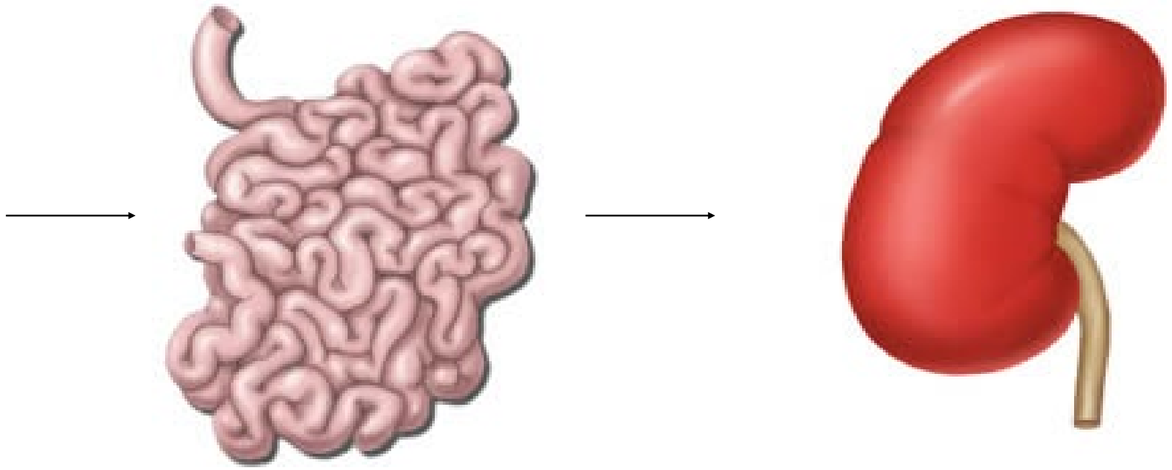
Clarke H. et al., Anesth Analg.115(2), 428-442, 2012

How they work:

- Absorption small intestine (Pregabalin substitution - more efficient absorption)
- Metabolism & Excretion
- No interactions



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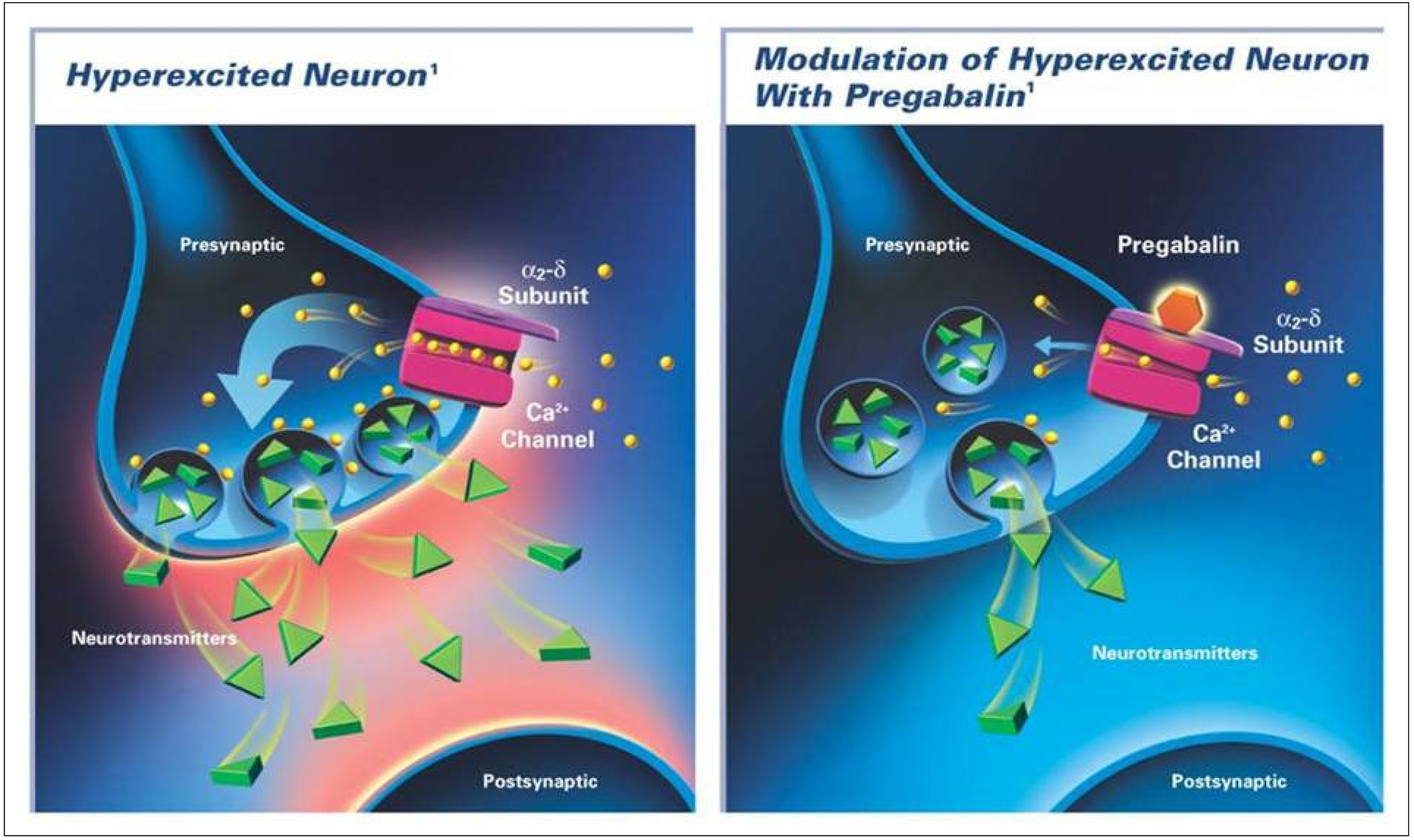
Hyperexcited Neuron[1]
Presynaptic
α2-δ Subunit
Ca2+ Channel
Neurotransmitters
Postsynaptic
Modulation of Hyperexcited Neuron With Pregabalin[1]
Presynaptic
Pregabalin
α2-δ Subunit
Ca2+ Channel
Neurotransmitters
Postsynaptic

Anticonvulsants: Gabapentin and Pregabalin

- Alcohol withdrawal
- Benzo weaning
- Opioid Weaning
- Use disorders

May be effective in generalized anxiety disorder with comorbid substance use disorder, and social anxiety disorder that does not respond to first line treatments

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Attal et al., 2010; Finnerup et al., 2015; Moulin et al., 2014, Coplan et al., 2015

Anticonvulsants: Gabapentin and Pregabalin

- Post Herpetic Neuralgia
- Painful Diabetic Neuropathy
- Fibromyalgia

*Minimal efficacy for treating HIV neuropathy

NNT: in the 5.0 PDN and 5.6 range PHN

*Risk of Suicidality in Adolescent patients

Attal et al., 2010; Finnerup et al., 2015; Moulin et al., 2014, Coplan et al., 2015

Opioids

- Health Canada has reported 40,642 apparent opioid toxicity deaths between Jan 2016 & June 2023
- From January to June 2023: 22 deaths / day
- From January to June 2023: 17 hospitalizations per day – total opioid related deaths 5% higher than in 2022
- Once COVID started – we saw an escalation of suicides in our program
- Fatal risk doubles from 20 mg to 50 mg daily and 10x if > 90mg (Prescription opioids, CDC data)

Opioid Crisis and Pain are Intertwined

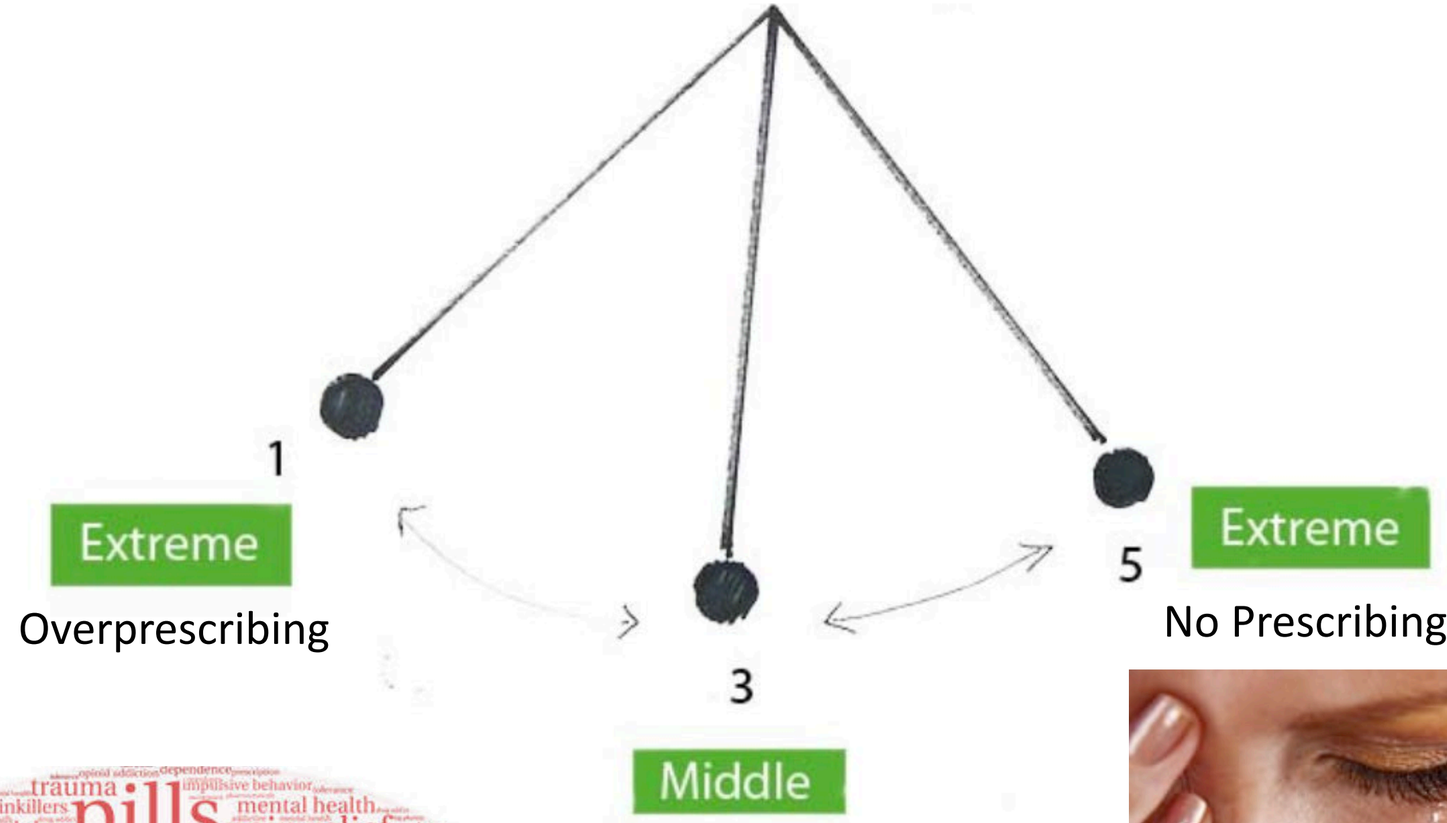
Significant intersections between chronic pain, substance use and the overdose crisis

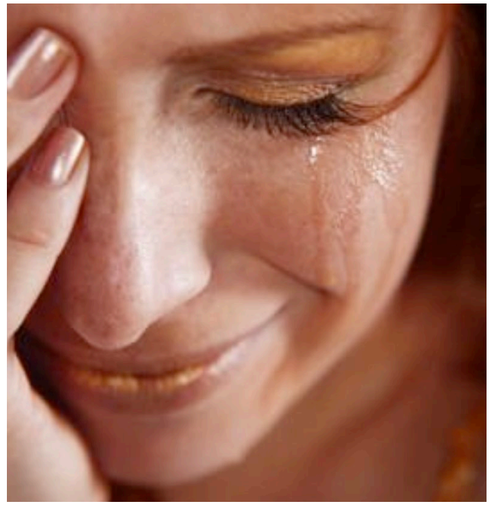
- **55%** of people who use drugs also live with chronic pain
- **45%** of people who died from illegal drug overdose (BC 2018) having sought pain services in the year prior to deaths

Actions to promote appropriate use of opioids led to unintended consequences

- Health professionals reported fear of **regulatory scrutiny**, **inadequate training**, **insufficient time** to manage opioid prescribing for chronic pain.
- People were **rapidly tapered or cut off** from their opioid medications
- **Increased stigma** for people living with pain

Opioid Prescribing Pain Patient Pendulum

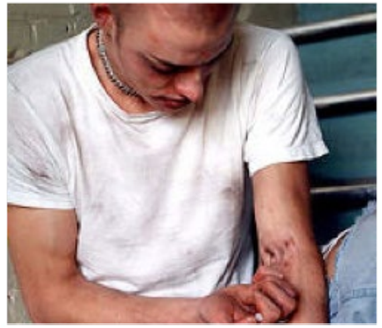




Problematic Opioid Use

- HIGH RISK
  - Multiple street drugs
  - i.v., snort,
- LOW RISK
  - Uses as directed
  - Patient choice to discontinue
  - Complications (sleep apnea, etc)

- MEDIUM RISK
  - Chemical coping
  - Medical diagnosis
  - overuse



Mu Opioid Receptor x

- Not a psychiatric medication
- Vulnerable patients can misuse them for their opioid effects
- Mu1 – euphoric effects (oxycodone is the winner)
- Mu2 – physical dependence

While opioids are effective first-line agents for management of severe, acute pain, their role in management of chronic pain has been called into question because of the side effects and the risk of substance misuse, particularly in patients with psychological disorders.

Benzodiazepines

Benzodiazepines are not analgesics, but up to **one third** of patients taking chronic opioids for non-cancer pain have reported concurrent benzodiazepine use and concurrent use of opioids and benzodiazepines is a consistent, strong predictor of problematic opioid use and increased risk of opioid overdose.

- 4 trials short term relief of low back pain, less evidence that non-benzo muscle relaxants

Cannabis

- A few small studies and many observational trials demonstrating efficacy for cannabis for chronic pain

- 2014 Canadian Pain Society Consensus Statement on Chronic Neuropathic Pain suggested using cannabinoids as a third-line agent for management of neuropathic pain

Canadian Pain Society guidelines

CONSENSUS STATEMENT

Pharmacological management of chronic neuropathic pain: Revised consensus statement from the Canadian Pain Society

DE Moulin MD, A Boulanger MD, AJ Clark MD, H Clarke MD PhD, T Dao DMD PhD, GA Finley MD, A Furlan MD PhD, I Gilron MD MSc, A Gordon MD, PK Morley-Forster MD, BJ Sessle MDS PhD, P Squire MD, J Stinson RN PhD, P Taenzer PhD, A Velly DDS PhD, MA Ware MD, EL Weinberg MD, OD Williamson MBBS

Recent update moved cannabinoids from fourth-line to third

"The cannabinoids are analgesic agents with increasing evidence of efficacy in central NeP states, with a combined NNT of 3.4"
— 2014

Gabapentinoids ←→ TCA ←→ SNRI

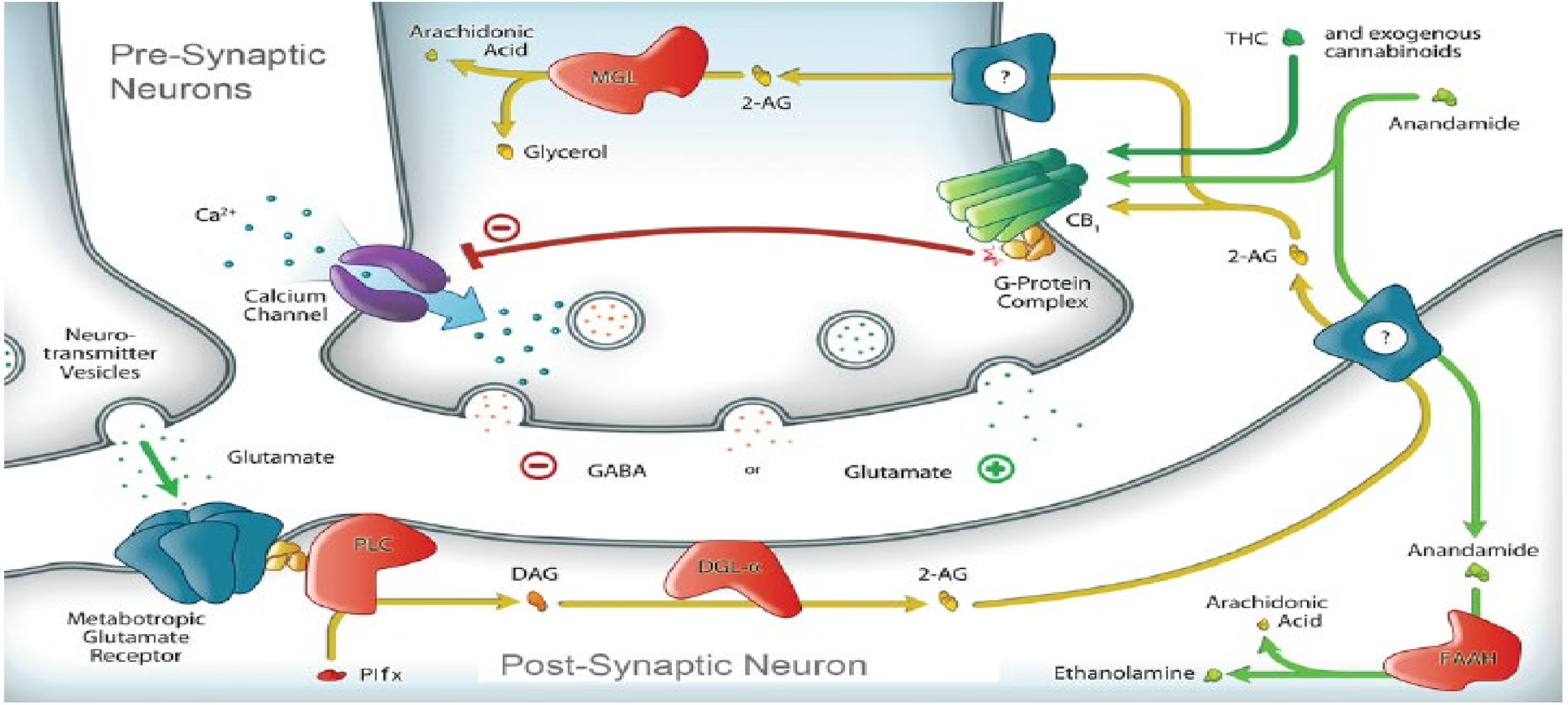
Tramadol ←→ Opioid analgesics

Cannabinoids

Fourth-line agents

Consider adding additional agents sequentially if partial but inadequate pain relief

Endocannabinoid System



EUROPEAN PAIN FEDERATION (EFIC) POSITION PAPER ON CANNABIS-BASED MEDICINES FOR CHRONIC PAIN

Medical Condition	EFIC Recommendation	Medical Condition
Cancer pain not adequately responding to opioids or other established analgesics	Sativex® (nabiximols) as an add-on individual therapeutic trial	Cancer pain not adequately responding to opioids or other established analgesics
Chronic neuropathic pain	Cannabis-based medicine considered for third-line therapy	Chronic neuropathic pain
Chronic non-neuropathic non-cancer pain	Cannabis-based medicine on an individual trial basis if patients have failed traditional treatments. Need multidisciplinary assessment of patient.	Chronic non-neuropathic non-cancer pain

Häuser W *et al*. *European Journal of Pain*. 2018;22(9):1547-1564.

Side effects

SCHIZOPHRENIA/PSYCHOSIS

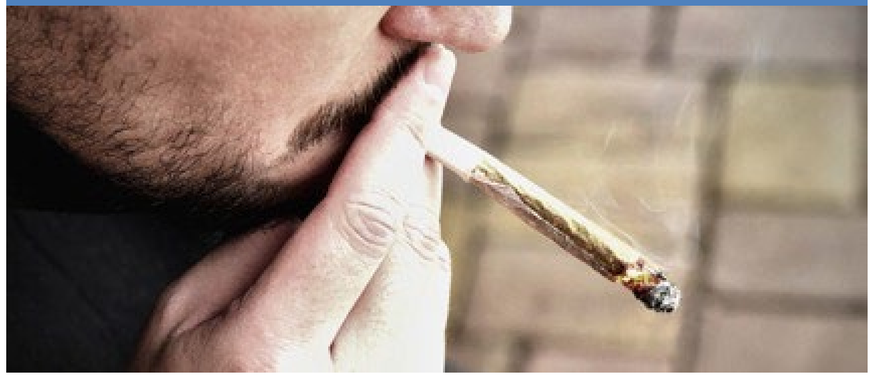
ADOLESCENT USE

Short-term

&

long-term

SMOKING CANNABIS



CANNABIS USE DISORDER

1. Kraan T et al., Psych Med 2016. 2. Luzi S et al., Neurotox Res 2008. 3. Lopez-Quntero et al., Drug Alcohol Dep 2011. 4. Fergusson DM et al., Psych Med 2003. 5. Meier MH et al., PNAS 2012.
6. Tashkin DP. Ann Am Thorac Soc 2013. 7. Gordon AJ et al., Curr Psychiatry Rep 2013.

MyMedi.ca
MEDICAL CANNABIS CARE

Medical Cannabis Real World Evidence (MC RWE)

medical cannabis by SHOPPERS

AVICANNA™

UHN
Toronto General
Toronto Western
Princess Margaret
Toronto Rehab
Michener Institute
COURAGE LIVES HERE

mc r w e
medical cannabis real world evidence

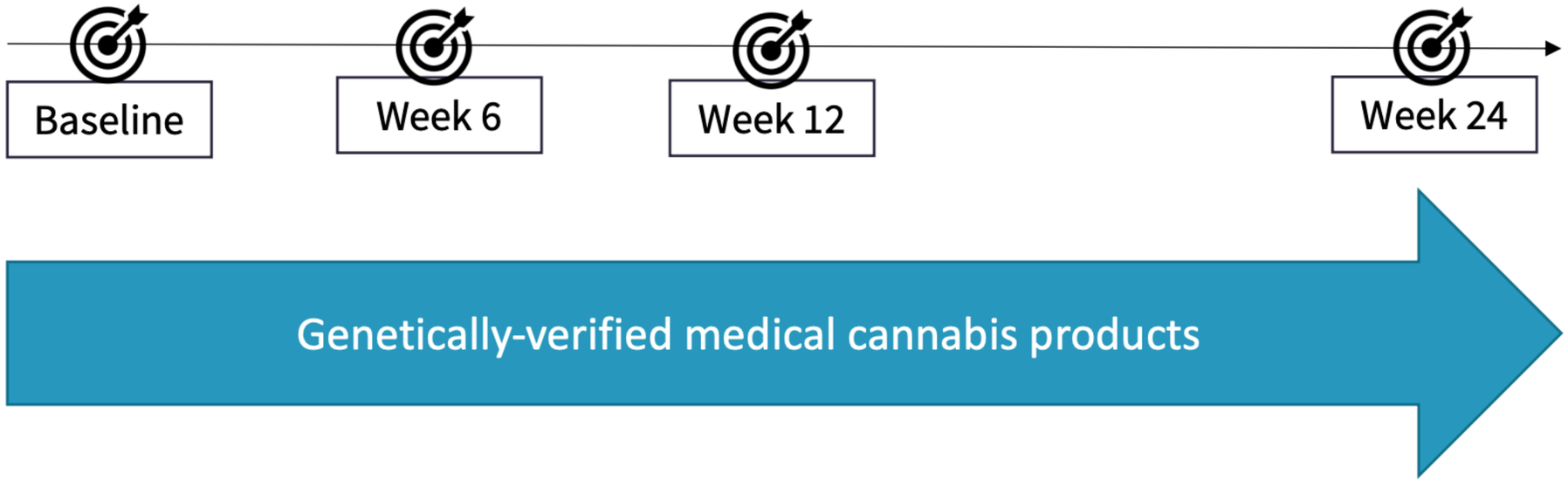
RWE Clinical Trial

MyMedi.ca
MEDICAL CANNABIS CARE

Adults >19 years of age with a valid medical document

Chronic pain, sleep and anxiety

Register with Medical Cannabis by Shoppers



Assessment using validated scales for pain, sleep, or anxiety

- PROMIS Pain Interference Short Form 6 and Numerical rating scale
  Pittsburgh Sleep Quality Index
- Generalized Anxiety Disorder-7 scale
- Patient Health Questionnaire-9 scale (depression)
- EuroQoL-5D (general health-related quality of life)
- Patient Satisfaction survey

Preliminary Results MCRWE

- Total cohort of 266 patients of which 215 reported pain as a primary indication of use

- Mean Age 49.1 ± 16.3 years
- 69% were female
- 39% had chronic pain
- 37% were currently using opioid medications

Transitional PAIN SERVICE
Working together to relieve pain

Yang et al., under review CJP, 2025

Outcomes over 6 months

Table 2. Cohort outcomes throughout study.

	Pain right now		Pain interference		Quality of life index	
Time						
Baseline	5.47 (2.38)		22.98 (5.98)		54.40 (19.02)	
Missing, n		*18*		*18*		*23*
6 weeks	4.76 (2.57)		19.29 (6.64)		61.50 (17.28)	
Missing, n		*74*		*74*		*75*
12 weeks	4.73 (2.51)		19.33 (6.74)		59.18 (19.86)	
Missing, n		*92*		*92*		*96*
24 weeks	4.15 (2.56)		18.21 (7.26)		56.01 (20.81)	
Missing, n		*118*		*118*		*120*

Values displayed are mean (SD).

Transitional PAIN SERVICE
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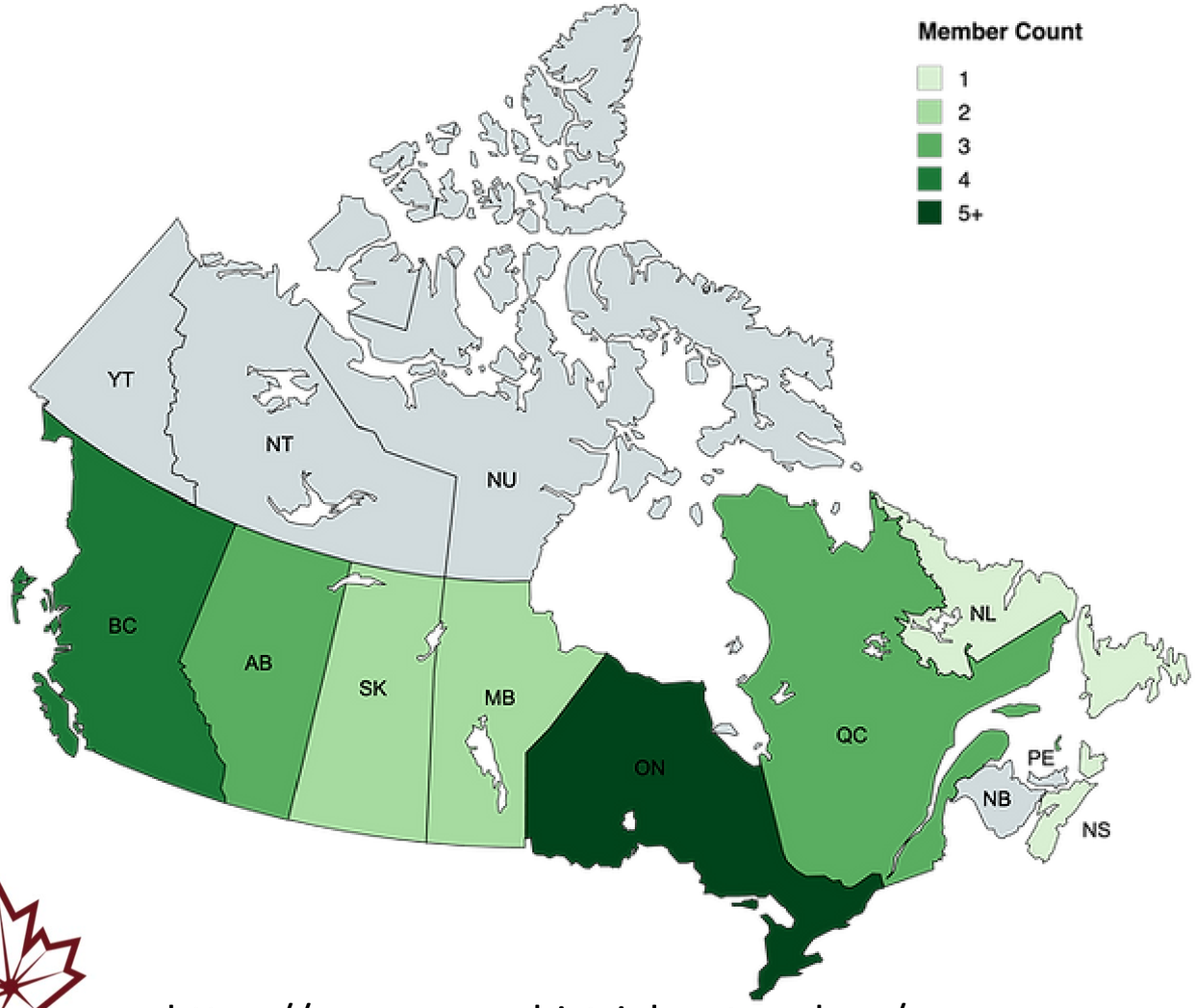
Yang et al., under review CJP, 2025

CMCN
Canadian Medical Cannabis Trials Network



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MD, PhD, FRCPC


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- One in eight Canadian adults use cannabis for medical purposes, but most indications lack high-quality evidence.
- The Canadian Medical Cannabis Trials Network will address this knowledge gap by supporting high-quality, rigorous trials of medical cannabis products.

https://www.cannabistrialsnetwork.ca/

Complex Pain Patient Care

University Health Network

Toronto General Hospital Toronto Western Hospital Princess Margaret Hospital

Opioid Weaning in the Chronic Pain Patient with OUD

Journal of Pain Research

Dovepress
open access to scientific and medical research

Open Access Full Text Article

CASE REPORT

A case report on the treatment of complex chronic pain and opioid dependence by a multidisciplinary transitional pain service using the ACT Matrix and buprenorphine/naloxone

This article was published in the following Dove Press journal:
Journal of Pain Research
27 March 2017
Number of times this article has been viewed

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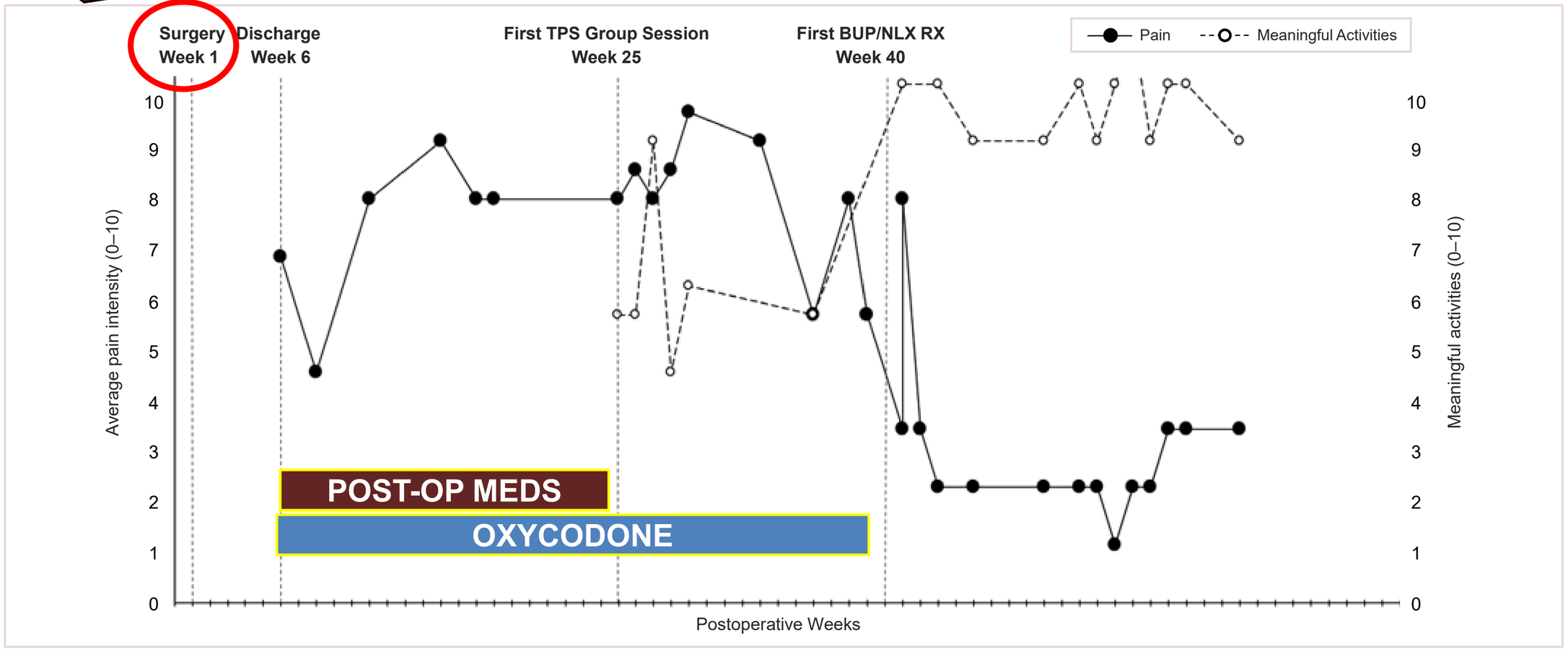
Weinrib et al. 2017, Journal of Pain Research

Opioid Weaning in a Long-term Opioid Patient



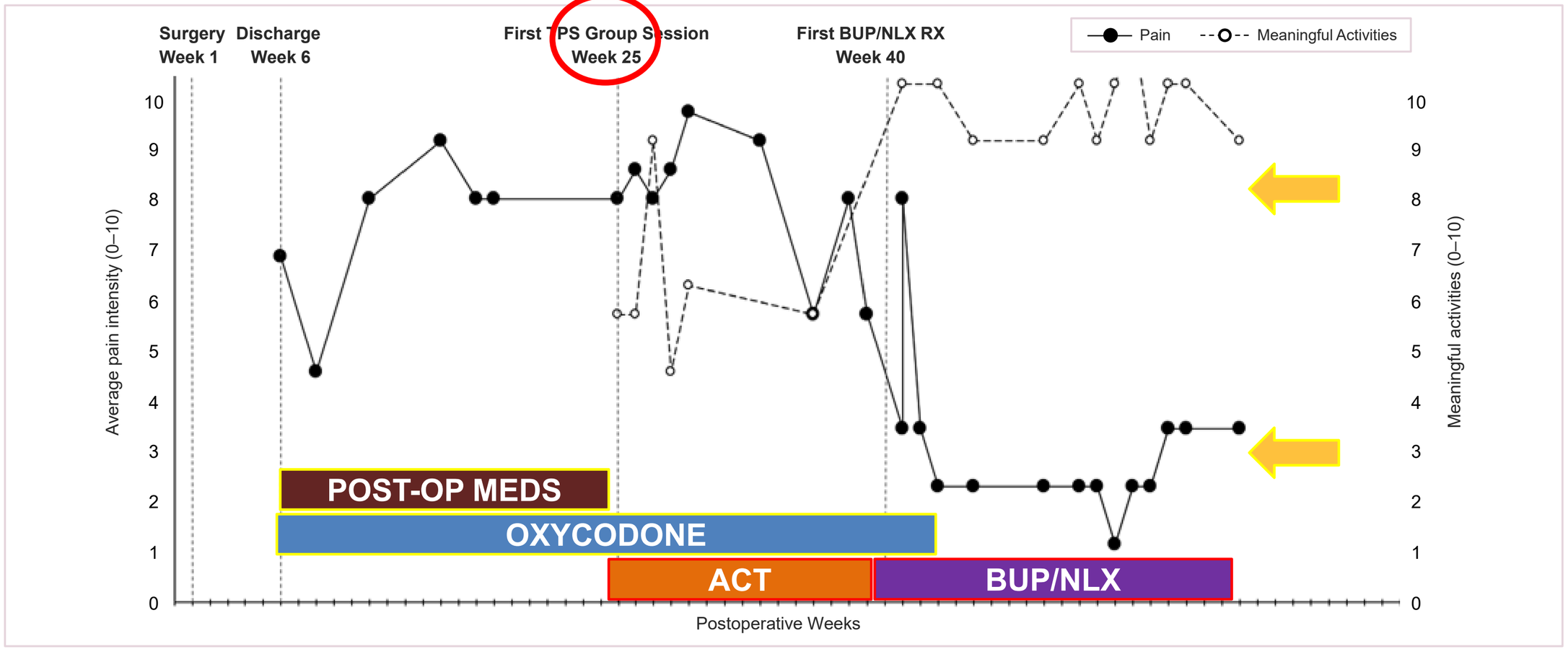
Average pain intensity scores and engagement in meaningful activities over follow-up period.

Notes: Pain was measured using a numeric pain rating scale ranging from 0 (no pain) to 10 (worst pain imaginable). Level of engagement in meaningful activities was assessed from the start of group therapy using a numeric rating scale ranging from 0 (not doing anything that matters) to 10 (doing everything that matters). Single case report.

BUP/NLX, buprenorphine/naloxone; TPS, transitional pain service

J Pain Res. 2017; 10: 747–755.

Opioid Weaning in a Long-term Opioid Patient



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Remote buprenorphine-naloxone initiation as an essential service for people with chronic pain and opioid dependence during the COVID-19 pandemic: Case reports, clinical pathways, and implications for the future

Hance Clarke[a,b,c], Aliza Weinrib[b,d], Yuvaraj Kotteeswaran[a,b], Joel Katz[a,b,c,d], Alvis Yu[e,f], and Robert Tanguay[f,g,h]

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ABSTRACT

Many health care professions have reacted swiftly to the COVID-19 pandemic. In-person care has been ramped down and telemedicine/telehealth has been thrust to the forefront of clinical care. For people living with chronic pain and often concomitantly dealing with opioid-related issues, this is a time of great stress. With population-wide movements to shelter in place, people living with pain are more isolated, more stressed, and more vulnerable to mental health concerns like depression and anxiety that can increase pain-related suffering. This article presents two case reports of patients struggling with chronic pain and opioid dependence in which a telemedicine-based buprenorphine-naloxone conversion was chosen as a treatment option by two Canadian programs: The Transitional Pain Service at the Toronto General Hospital in Toronto, Ontario, and The Opioid Deprescribing Program in Calgary, Alberta. Both cases presented highlight the use of telemedicine during the COVID-19 pandemic and suggest that there will be substantial need for these services well beyond the apex of the crisis. A buprenorphine-naloxone home induction protocol is presented and we provide insight into important lessons learned regarding the appropriate selection of patients with chronic pain struggling with opioid use disorder for buprenorphine-naloxone conversion. The provision of health care during the COVID-19 pandemic has rapidly forced practitioners to evolve novel health care practices, and these changes will have long-term implications.

ARTICLE HISTORY
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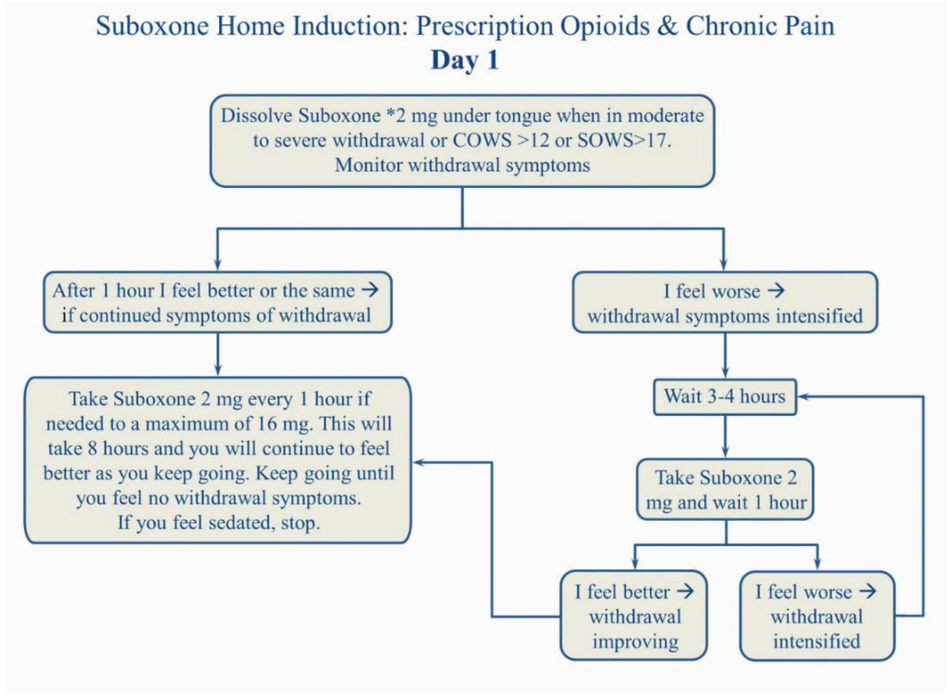
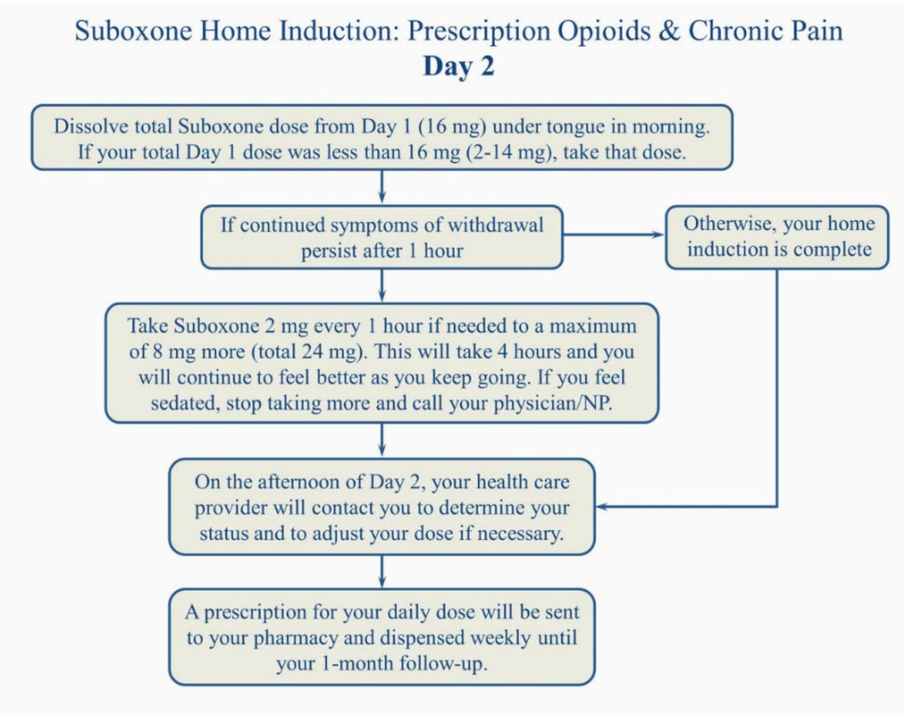
KEYWORDS
chronic pain; suboxone; COVID-19; telemedicine; buprenorphine-naloxone; telepsychology

Buprenorphine-naloxone Home Induction Protocol





Clarke, Weinrib, Kotteeswaran et al. Canadian Journal of Pain, Sept. 2020

TPS Psych protocol for buprenorphine-naloxone (Ladak et al., under review)

- Support all buprenorphine-naloxone inductions
- ~2 sessions prior to initiation
  - Motivational interviewing
  - Psychoeducation
  - Coping planning (DBT skills)
- ~2-3 sessions after initiation
  - Coping support, continued MI

Standards for Managing Pain in Patients with OUD

Prescribers are responsible for managing pain in their patients on OAT whenever possible.

Patients are supported in finding alternative pain treatments that are financially and geographically accessible and culturally appropriate.

OAT: opioid agonist therapy.

Centre for Addiction and Mental Health. Opioid Agonist Therapy: A Synthesis of Canadian Guidelines for Treating Opioid Use Disorder. Published May 2021. Available at www.camh.ca. Accessed September 6, 2024.

Clinical Recommendations for Managing Pain

- Explore non-pharmacological approaches
  - Consider non-opioid medications before adding opioids
  - Osteoarthritis, Back Pain, Muscle Pain
    - If prescribing opioids for acute pain, limit amounts
    - For people on opioid agonist treatments
    - Consider in split doses for severe chronic pain that requires opioids
- Consider consulting with a pain specialist if chronic pain develops and persists for months

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An examination of referrals declined for chronic pain care: There is increasing mental health complexity within care-seeking patients with chronic pain over time

Rachael Bosma[a], Brittany N. Rosenbloom[a], Emeralda Burke[a], Christian Aquino[a], Cara Stanley[a], Kimberly Coombs[a], Adriano Nella[a], Shamalla James[a], Hance Clarke[b,c], David Flamer[d], Anuj Bhatia[a,e,f,g], John Flannery[h], Andrew Smith[i], and Tania Di Renna[a,f]

- Retrospective chart review of all declined referrals at TAPMI in 2018 and 2022 was conducted
- Number of declined referrals due to mental health complexities increased significantly:
  - 2018: 51 (11%) → 2022: 180 (18%) (χ^2=10.9, p=0.0009)
  - Significant rise in the number of declines due to mental health service requests was also observed (χ^2=24.53, p<0.00001)

National Landscape:
One in four Canadian multidisciplinary pain treatment centre excluded patients if a co-occurring mental health disorder and/or a substance use disorder was present

TAPMI: Toronto Academic Pain Medicine Institute.

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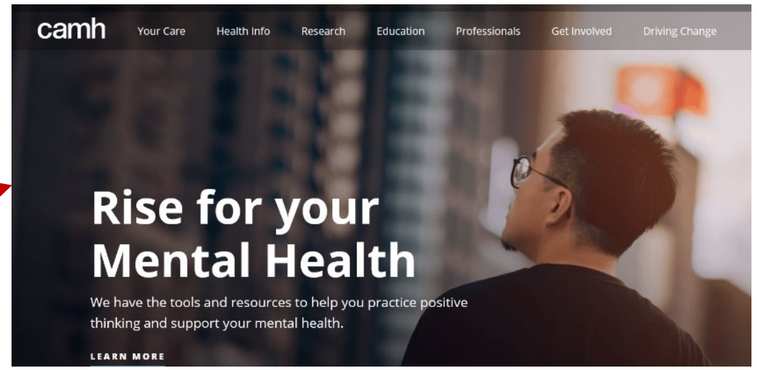
- To tackle complexity of patient population, further specialized resources that combine both pain and mental health care are required
- Patients with co-occurring pain and mental health concerns may require longitudinal care
- In current health care models, such as in Ontario, funding for pain care is based on the number of new referrals and patients are expected to be discharged within a year (i.e. acute care model)
- The Canadian Pain Task Force has recently acknowledged disparity in health care due to mental health concerns and highlighted equitable access to comprehensive care as a pillar of focus
- Inpatient care models are being attempted to be created at some centres; outpatient models are scarce

Building Community Connections

Transitional PAIN SERVICE
Working together to relieve pain



TAPMI
Toronto Academic Pain Medicine Institute

RAAM Clinics (HCP Website Referral)

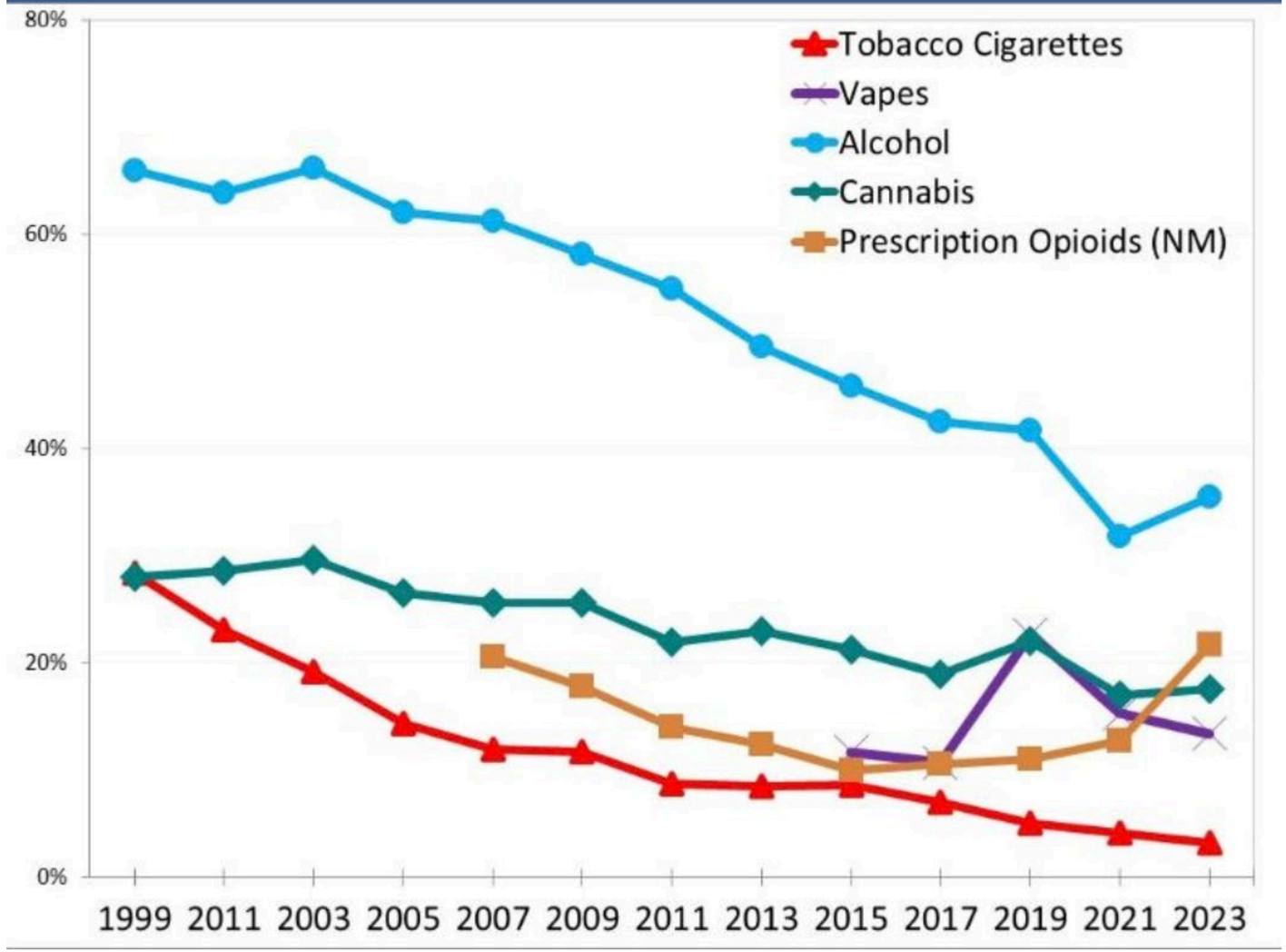
HCP: health care professional; RAAM: Rapid Access Addiction Medicine; TAPMI: Toronto Academic Pain Medicine Institute.

Treating Pain in People With Concurrent Conditions

Take Home

- Chronic Pain and Mental Health conditions are intertwined
- Specialized training is needed by providers in both clinical environments
- Better discourse is often needed when co-managing patients
- Neurobiology and Neurochemistry are at the heart of Chronic Pain and Mental Health treatment

Percentage of students reporting past year drug use (selected drugs), 1999–2023 OSDUHS (Grades 7–12)



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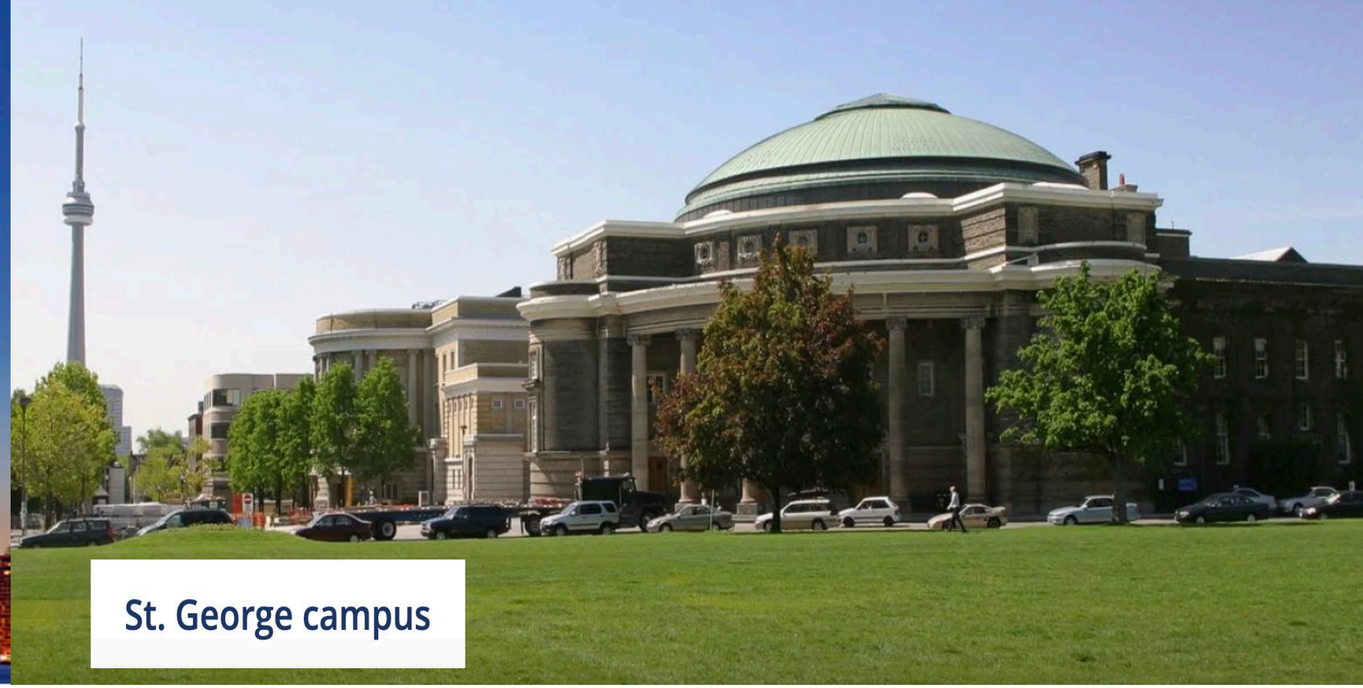

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Friday May 2nd

The Canadian Pain Society
45th Annual Scientific Meeting
May 1 – 4, 2025
Toronto, Canada
University of Toronto Campus

Full Conference Info

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Questions

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