SIP Position Paper on Mental Health and Pain

2023

Key Recommendations

SIP calls upon EU and national policy makers to:

- Incorporate pain assessment into routine assessment of people living with mental health disorders, such as major depression, bipolar disorder, schizophrenia, and substance use disorders.
- Incorporate pain treatment into mental health treatment plans for people living with mental health disorders, such as major depression, bipolar disorders, schizophrenia, and substance use disorders.
- Better integrate physical and mental health services, such as treatment of pain and mental health disorders, instead of treating them in isolation in separate services.
- Provide early access to multimodal pain management programmes for people with a high risk of developing chronic pain and those with chronic pain, to serve as a preventive programme for mental health disorders.
- Provide training to healthcare professionals in the strong bidirectional relationship between pain and mental health outcomes.
- Involve people with lived experience of mental health disorders and physical illnesses featuring pain, in developing integrated services.
- Allocate adequate funding for research on the relationship between mental health and pain.
- Ensure that the biological, psychological, and social factors of pain are comprehensively addressed in mental health policies.
- Recognise that good work can have a positive impact on physical health and mental wellbeing and therefore, the reintegration and adaptation of people living with back pain and/or mental health disorders, into the workforce should be supported.

Background

In Europe[1] there are approximately 740 million people, most of whom experience an episode of severe pain at some point in their life. For approximately 20 percent, that pain is chronic pain. This means that, at present, 150 million people are experiencing pain across Europe, approximately equal to the population of France and Germany combined.

In 2018, the 'Societal Impact of Pain' (SIP) platform, a multi-stakeholder partnership led by the European Pain Federation EFIC and Pain Alliance Europe (PAE),) published its Joint Statement which includes recommendations for action and collaboration by the European Commission, Member States, and civil society to reduce the societal impact of pain. These recommendations form the over-arching and guiding principles for SIP, and are divided into four categories: health indicators, research, employment, and education.

SIP's Joint Statement calls to explore opportunities to build on existing instruments which are available to define, establish and / or use pain as an indicator in the assessment of healthcare systems' quality, as this will contribute to assessing and filling the data gap on the societal impact of pain.

[1] Note: data taking from 37 countries, absent in Andorra, Armenia, Azerbaijan, Belarus, Georgia, Iceland, Liechtenstein, Luxembourg, Malta, Monaco, and the Vatican City.

European Pain Federation EFIC®, Rue de Londres - Londenstraat 18, B1050 Brussels. Transparency Register no. 3510244568-04
The 'Societal Impact of Pain' (SIP) platform is a multi-stakeholder partnership led by the European Pain Federation EFIC and Pain Alliance Europe (PAE), which aims to raise awareness of pain and change pain policies. The scientific framework of the SIP platform is under the responsibility of EFIC and the strategic direction of the project is defined by both partners. The pharmaceutical companies Grünenthal GmbH and GSK are the main sponsors of the Societal Impact of Pain (SIP) platform

Mental health and pain significantly influence each other, and the recompilation below outlines their close connections, and the implications of this for health policy.

1. The Close Relationship Between Pain and Mental Health

Mental health disorders and chronic pain frequently co-occur due to overlapping biological pathways and shared risk factors including poverty, unemployment, high rates of manual labour, and lack of access to mental healthcare services. For instance, depression and pain commonly co-occur, with an estimated co-morbidity rate of 65%. Additionally, pain prevalence is high in people with bipolar disorder, with data showing that 29% of people with bipolar disorder report pain (mainly chronic musculoskeletal pain and migraine) - over double the risk of people without a mental health problem. Moreover, people without a mental health problem are at high risk of developing one if they still have moderate to severe pain after 12 months. People with mental health disorders, such as major depression, bipolar disorder and schizophrenia, and pain have substantially poorer physical health, increased risk of cancer and cardiovascular-related disease – all contributing to a lower life expectancy.

2. Pain and Mental Health Disorders are Both Biopsychosocial Experiences

Pain, like mental health disorders, is best conceptualised as a biopsychosocial experience involving a complex interaction between biological, psychological, and social factors. Contemporary management of pain places a large focus on multimodal assessment and treatment, where all these factors are addressed where relevant to each individual patient. Ideally to achieve this, patients with chronic pain should have early access to integrated care services involving multiple disciplines. In chronic pain, mental health professionals like psychologists, work as part of a multidisciplinary team to deliver psychosocial interventions such as cognitive behavioural therapies, exposure, and relaxation activities. Psychosocial interventions have good evidence of benefit for chronic pain, but many patients do not have access to them.

3. Pain and Mental Health Disorders are Mutually Reinforcing – Creating a Vicious Cycle of Disability

Pain and mental health influence each other, capable of creating a vicious cycle of disability. Both pain and mental health disorders cause reduced quality of life, mobility and social participation, across the lifespan. In addition, the treatment of mental health disorders is less successful if patients also have chronic pain, and the treatment of chronic pain is less successful if patients also have a mental health disorder.

People with pain and mental health disorders are less likely to be in full-time employment and report substantially higher rates of absenteeism and presenteeism (being present at work but working at reduced capacity), compared to those reporting no pain. In Europe, musculoskeletal pain is responsible for 50% of sickness absences and 60% of permanent disabilities.

Both pain and mental health disorders interfere with sleep quality and physical activity levels, which are independent risk factors for pain and mental health disorders like depression. Additionally, both severe mental health disorders and pain are associated with increased suicide risk.

Furthermore, some medications for pain (e.g., opioids) are capable of producing mental health symptoms in patients. The risk of substance use disorders is high with many pain relievers and, in particular, with opioids. In some, but not all, European countries, mortality from opioid use has increased over the past two decades. A number of data suggest that this may have been increased by the prescription of opioids (substantially increased, but very heterogeneously). Paradoxically, chronic pain is a major problem for 1 in 2 people with opioid use disorders. Overall, Europe has much to do to improve the quality of and access to safe pain management.

In turn, chronic pain influences the effectiveness of both pharmacotherapy and psychotherapy for mental health conditions such as depression. Musculoskeletal pain, depression, and anxiety increase the risk of disability, and comorbidity between them increases the risk further. Therefore, not identifying patients at risk for developing or already having comorbid mental health disorders and pain, early on, can lead to insufficient treatment of both diseases, while awareness of a potentially increased risk could lead to the employment of preventive strategies. Therefore, pain is an important moderator of mental health treatment engagement, adherence, and outcomes.

4. Integrating Pain into Mental Health Policy - Practice Will Maximise Treatment Effectiveness

Pain is not routinely assessed and managed in people with mental health disorders, and pain communication and assessment might be obscured by the nature of mental health disorders, such as psychosis. Mental health disorders are highly stigmatised, which can be a barrier for recognition. This needs to change as identifying people with mental health disorders, who have or are at risk of experiencing pain, is essential to prevention and early intervention. Therefore, it is crucial to incorporate pain and its treatment into mental health case assessment and treatment plans. Mental health professionals are ideally positioned to do this given their knowledge of the biopsychosocial model of illness. Incorporating pain into mental healthcare may aid in maximizing treatment effectiveness for both pain and mental health disorders. Since pain and mental health disorders are mutually reinforcing, integrated treatments targeting both conditions, may treat both conditions more efficiently than single-focus treatments. Mental health professionals can reinforce positive pain behaviours, for example, by engaging in exercise and emotional regulation activities, and addressing unhelpful ways of thinking. In this way, mental health professionals serve as partners in an integrated pain care plan. Recognising and addressing pain in mental health settings and policies may be an untapped avenue for more optimally meeting the needs of both patients with chronic pain and mental health disorders.

5. References

- Bair MJ, Robinson RL, Katon W, Kroenke K. Depression and pain comorbidity: a literature review. Archives of internal medicine. 2003 Nov 10;163(20):2433-45.
- Bondesson E, Larrosa Pardo F, Stigmar K, Ringqvist Å, Petersson IF, Jöud A, Schelin ME. Comorbidity between pain and mental illness–evidence of a bidirectional relationship. European Journal of Pain. 2018 Aug;22(7):1304-11.
- De Heer EW, Ten Have M, Van Marwijk HW, Dekker J, De Graaf R, Beekman AT, Van Der Feltz-Cornelis CM. Pain as a risk factor for common mental disorders. Results from the Netherlands Mental Health Survey and Incidence Study-2: a longitudinal, population-based study. Pain. 2018 Apr 1;159(4):712-8.
- Demyttenaere K, Bruffaerts R, Lee S, Posada-Villa J, Kovess V, Angermeyer MC, Levinson D, de Girolamo G, Nakane H, Mneimneh Z, Lara C. Mental disorders among persons with chronic back or neck pain: results from the World Mental Health Surveys. Pain. 2007 Jun 1;129(3):332-42.
- Eccleston C, Morlion B, Wells C. Pain in Europe. Oxford University Press; 2018.
- Edmond SN, Heapy AA, Kerns RD. Engaging mental health professionals in addressing pain. JAMA psychiatry. 2019 Jun 1;76(6):565-6.
- Forget P, Hauser W. Europe has much to do to improve the quality of and access to safe pain management. Lancet 2023 [Under review]
- Gatchel RJ. Comorbidity of chronic pain and mental health disorders: the biopsychosocial perspective. American Psychologist. 2004 Nov;59(8):795.
- Kim DJ, Mirmina J, Narine S, Wachtel J, Carbajal JM, Fox H, Cáceda R. Altered physical pain processing in different psychiatric conditions. Neuroscience & Biobehavioral Reviews. 2022 Feb 1;133:104510.

- Kohrt BA, Griffith JL, Patel V. Chronic pain and mental health: integrated solutions for global problems. Pain. 2018 Sep;159(Suppl 1):S85.
- McLaren N, Kamper SJ, Hodder R, Wiggers J, Wolfenden L, Bowman J, Campbell E, Dray J, Williams CM. Increased substance use and poorer mental health in adolescents with problematic musculoskeletal pain. journal of orthopaedic & sports physical therapy. 2017 Oct;47(10):705-11.
- Noel M, Groenewald CB, Beals-Erickson SE, Gebert JT, Palermo TM. Chronic pain in adolescence and internalizing mental health disorders: a nationally representative study. Pain. 2016 Jun;157(6):1333.
- Onwumere J, Stubbs B, Stirling M, Shiers D, Gaughran F, Rice AS, de C Williams AC, Scott W. Pain management in people with severe mental illness: an agenda for progress. Pain. 2022 Sep 1;163(9):1653-60.
- SIP thematic network 2018 - joint statement [Internet]. Societal Impact of Pain (SIP). EFIC, PAE; 2019 [cited 2023 Feb 7]. Available from: https://www.sipplatform.eu/resources/details/sip-thematic-network-2018-joint-statement
- Stickley A, Koyanagi A, Kawakami N, WHO World Mental Health Japan Survey Group. Childhood adversities and adult-onset chronic pain: results from the World Mental Health Survey, Japan. European Journal of Pain. 2015 Nov;19(10):1418-27.
- Stubbs B, Aluko Y, Myint PK, Smith TO. Prevalence of depressive symptoms and anxiety in osteoarthritis: a systematic review and meta-analysis. Age and ageing. 2016 Mar 1;45(2):228-35.
- Stubbs B, Eggermont L, Mitchell AJ, De Hert M, Correll CU, Soundy A, Rosenbaum S, Vancampfort D. The prevalence of pain in bipolar disorder: a systematic review and large-scale meta-analysis. Acta Psychiatrica Scandinavica. 2015 Feb;131(2):75-88.
- Stubbs B, Gardner-Sood P, Smith S, Ismail K, Greenwood K, Patel A, Farmer R, Gaughran F. Pain is independently associated with reduced health related quality of life in people with psychosis. Psychiatry research. 2015 Dec 15;230(2):585-91.
- Stubbs B, Mitchell AJ, De Hert M, Correll CU, Soundy A, Stroobants M, Vancampfort D. The prevalence and moderators of clinical pain in people with schizophrenia: a systematic review and large scale meta-analysis. Schizophrenia research. 2014 Dec 1;160(1-3):1-8.

--END—

SIP remains available for further discussions with the European Commission, the Members of the European Parliament, the Council, digital health technology developers, and civil society stakeholders for future cooperation to ensure our recommendations are implemented in the area of digital health and pain.

About SIP

The 'Societal Impact of Pain' (SIP) platform is a multi-stakeholder partnership led by the European Pain Federation EFIC and Pain Alliance Europe (PAE), which aims to **raise awareness of pain** and **change pain policies**.

The platform provides opportunities for discussion for health care professionals, pain advocacy groups, politicians, healthcare insurance providers, representatives of health authorities, regulators, and budget holders.

The scientific framework of the SIP platform is under the responsibility of EFIC and the strategic direction of the project is defined by both partners. The pharmaceutical companies Grünenthal GmbH and GSK are the main sponsors of the Societal Impact of Pain (SIP) platform.

Contacts: For further information, please contact:

Ángela Cano Palomares, Project Manager, Societal Impact of Pain (SIP) Europe, at European Pain Federation EFIC – angela.palomares@efic.org

Emilia Kosińska, Association and Projects Manager, PAE – emilia.kosinska@pae-eu.eu

European Pain Federation EFIC®, Rue de Londres - Londenstraat 18, B1050 Brussels. Transparency Register no. 3510244568-04
The 'Societal Impact of Pain' (SIP) platform is a multi-stakeholder partnership led by the European Pain Federation EFIC and Pain Alliance Europe (PAE), which aims to raise awareness of pain and change pain policies. The scientific framework of the SIP platform is under the responsibility of EFIC and the strategic direction of the project is defined by both partners. The pharmaceutical companies Grünenthal GmbH and GSK are the main sponsors of the Societal Impact of Pain (SIP) platform