Pain Management in Patients with Substance Use Disorders

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Representing the Position Paper Taskforce

American Society for Pain Management Nursing
Position Statement:
Pain Management in Patients with Substance Use Disorders

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A Collaborative, Professional Endeavor
Nomenclature

“It is anticipated that the terms substance abuse and substance dependence will be discontinued with the release of DSM 5, which is expected in May, 2013, in favor of a single, combined category of substance use disorders, which will then be further delineated as moderate or severe (p.9).”

History- helping to define this journey...

◆ In 2002, ASPMN published the Position Statement Pain Management in Patients with Addictive Disease

◆ At the suggestion of Margo McCaffrey, a task force was established

◆ Task Force Members:
  Candace Coggins CARN,NP (Chairperson)
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History- helping to define this journey...

◆ Key points of contribution:
  ◆ Definition of addiction as a “...chronic, relapsing, treatable disease.”

  ◆ “…maintaining a balance between provision of pain relief and protection against inappropriate use of prescribed medications.”

  ◆ Clinical Recommendations for:
    ◆ All patients with addictive disease
    ◆ Patients who are actively using
    ◆ Patients receiving methadone maintenance
History - helping to define this journey...

The 2002 position paper

- Sought consensus from other professional organizations
- Was included by ASAM in the curriculum offered to members of their Pain Management SIG
- Fostered positive feedback from ASPMN nurses concerning the focus on clinical recommendations.

Background

- Prevalence in 12 years and older
  - Reported illicit substance use the previous month (2010) -- 22.6 million Americans (8.9%)
  - Nonmedical prescription pain reliever use
    - 5.1 million people
    - 60% of those individuals obtained prescription pain relievers from friend or relative
    - 80% of those friends or family obtained pain relievers from a single prescriber.
    - Emergency department visits -- increased 111%, 2004-2008

- Pediatric
  - Prescription opioids -- most commonly used drugs for nonmedical purposes [safer??]
  - Self-treatment or other reasons, diversion

- Geriatric (>50 years)
  - Nonmedical use
    - Increase up to 190%
  - Projection over two decades
    - 2001 -- 911,000
    - 2020 -- 2.7 million (Colliver, Compton, Gitsoyer, & Corden, 2006).
Background

- Top three medications:
  - Oxycodone, hydrocodone, and methadone products (SAMHSA, 2010).
- Unintentional deaths -- epidemic proportions
  (Centers for Disease Control and Prevention, 2010, 2011).
- Risk of death magnified when opioids taken in combination with alcohol, sedatives, hypnotics, and anxiolytics.

Background

- Financial impact of misuse to federal, state, and local governments
  - $467.7 billion per year (NCASA, 2011).
- The National Prescription Drug Threat Assessment survey:
  diversion -- doctor shopping, prescription fraud, and theft
  (National Drug Intelligence Center [NDIC], 2010).
- Estimated overall cost to public and private insurers
  - $72.5 billion per year

Stigma

- Stigmatizing terms creates prejudice and promotes a shame-based context of care (McCaffrey, et al., 2005)
  - “dirty versus clean urine drug tests”
- Use terms that promote an understanding of addiction as a medical condition
  - People with substance use disorders, active addiction
  - Positive or negative UDTs.
Stigma

- **Action**: Inadequate understanding or punitive application of adherence monitoring
- **Results**: Excludes patient from full array of pain management options.
- **Outcome**: Reducing and eliminating stigma, develop rapport, educate
  - Table 1 in position paper lists common misconceptions and corrects them.

Misconceptions

- **Example 1**: Addiction can accurately be predicted in patients and diagnosed at intake.
  
  - **Correction**: Addiction is not an entirely predictable response to reward producing drugs, but may occur in biologically and psychologically susceptible individuals; it is diagnosed over time, based on established criteria.

Misconceptions

- **Example 2**: Substance misuse is the same as substance abuse, dependence, or addiction, and requires stopping all opioids.
  
  - **Correction**: Many reasons for substance misuse:
    - varying cultural values
    - lack of education
    - misunderstandings
    - poor judgment
    - These do not meet criteria for a substance use disorder.
  
  - **Misuse does require evaluation for patient education and possible treatment modifications, but does not mandate discontinuation of opioids.**
Conceptual Models

- 12-step Model
  - View
    - underlying spiritual crisis
    - Personal isolation from one’s own values - i.e. emotional upheaval.
  - Treatment
    - Addressing individual powerlessness over addictive behaviors
    - followed by continued personal and group involvement, incorporating the 12-step principles into daily life
    - Considered to be the foundation to spiritual awakening and behavioral change (Halstead & Matthew, 2003).

Conceptual Models

- Disease Model
  - View
    - substance use disorders and addiction as chronic illnesses.
    - Addiction is a disorder of the brain with dysfunction of dopaminergic pathways controlling the brain’s impulse and decision-making centers.
    - These centers inhibit the ability to control impulses, including impaired control over drug use (Hyman, 2005; Ross & Pardes, 2009)

Conceptual Models

- Bio-psycho-social-spiritual Model
  - View
    - pain and addiction on a continuum of mutual interaction
    - Signs, symptoms, and patterns of behavior are evaluated when either pain or substance use disorders threaten an intact sense of self.
  - Treatment
    - biologic, psychologic, sociocultural, and spiritual processes interact to synergistically preserve, resume, or establish integration and wholeness within the individual.
A Few Helpful Definitions

- Universal Precautions
- Relapse
- Biopsychosocial-spiritual Model (BPSS)

Universal Precautions

- **What is it?** A 10 step systematic approach to the assessment & on-going management of chronic pain patients
- **What does it offer?** A triage scheme for estimating the risk of SUD/addiction with chronic pain patients
- **Why is it needed?** Impossible to reliably determine who will develop SUD especially on initial encounter
- **What benefits result?** Systematic evaluations, decreased provider fear and reactive responses, early detection & Rx of aberrant behaviors

Universal Precautions

- **Risk**
- **Benefit**
Universal Precautions for Level of Risk

- Define pain diagnosis
- Assess substance use and mental health
- Informed consent
- Treatment agreement
- Evaluate efficacy of medication pre and post treatment
- Re-assessment of pain and level of function
- Documentation

Regular assessment of the Five A’s
- Analgesia
- Activity
- Adverse effects
- Aberrant behavior
- Affect

Relapse of a Substance Use Disorder

- A return to a more active disease state with a resumption of alcohol or drug use due to impaired control and/or craving after a period of abstinence
- May be confused with pseudoaddiction

Biopsychosocial-spiritual Model (BPSS)

- Stress of pain, under-treatment of pain, and exposure to drugs affecting the dopaminergic pathway may trigger craving and influence the risk of relapse

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**Ethical Tenets**

**“Do No Harm”**

*Failure to treat pain is “an unethical breach of human rights”* (Brennen, Carr, & Cousins, 2007)

*Declaration of Montreal, 2010, recognizes the intrinsic dignity of all persons, and that withholding of pot treatment is profoundly wrong, leading to unnecessary suffering which is harmful.*

**Ethical Tenets**

When opioid therapy is initiated, an ethical imperative is created to monitor the patient regarding risk for inappropriate use and response to treatment throughout the trajectory of care.

**Ethical Obligations of Nurses:**

- Evaluate and treat problems associated with relieved pain
- Evaluate and treat problems associated with actual or potential risk of a substance use disorder or addiction
- Practice without stigmatizing patients
- Correct misconceptions in practice
- Advocate for holistic treatment of patients with pain and substance use disorders
Risk Stratification

- Categories to assess risk
  - Regarding concurrent or developing SUD in chronic pain pts.
- Fluid categories
  - Patients can move between categories at any time
  - Individual variability- Fast, slow, subtle or obvious risk
  - If Unclear - monitor over time
- Clinical Recommendations based on risk

### Low Risk
- No past/current history of SUD
- No family history of SUD
- No major untreated psychiatric disorder
- Presence of social support system
- May be safely managed in primary care settings
- Adherence monitoring at least annually

### Moderate Risk
- History of treated SUD
- Significant family history of SUDs
- Past or current psychiatric disorder
- Current addiction pharmacotherapy (methadone, buprenorphine)
- Younger than 25 years of age
- May be managed in primary care in consultation with appropriate specialist support
- Adherence monitoring every 6 months or less

### High Risk
- Active SUD or aberrant behaviors
- Active addiction
- Major untreated psychiatric disorder
- Recommended management by specialists (pain & addiction)
- Patients pose significant risk to themselves and others
- Frequent adherence monitoring weekly or monthly (Adapted from Gourlay et al., 2005)

RECOMMENDATIONS

*Applicable to ALL Patients - (low, moderate, high risk)*

- Utilize 10-Step Universal Precautions
- Consider multimodal & integrative therapy
- Utilize formal assessment tools and standard procedures
10 Universal Precautions for patients w/ chronic pain (Adapted from Gourlay, et al., 2005)

1) Define pain diagnosis
2) Psychological & SUD assessment
3) Informed Consent
4) Written Treatment Agreement
5) Eval pain & function pre/post Rx
6) Appropriate trial of opioids +/- adjuncts
7) Reassess pain & function
8) Regularly assess 5 A’s
9) Regular review of pain & comorbid dx
10) Documentation

Multimodal & Integrative Options

- Multimodal pharmacotherapy
- Interventional techniques (i.e. nerve blocks)
- Psychological/psychiatric Rx & support
- Coping skills enhancement
- Spirituality w/ patient consent (i.e. prayer, religious practice/support of clergy)
- 12 step programs
- Family involvement
- PT/OT
- Complementary/alternative therapy (i.e. acupuncture, mindfulness-based practices)

Formal Assessment Tools & Standard Procedures

- Benefits
  - Guides individualized care & limits legal liability
- Many formal tools available
- Procedures for adherence monitoring
  - Short refill intervals
  - Pill counts
  - UDT (Urine Drug Testing)
  - Prescription Monitoring Programs
Examples of Risk Assessment Tools

**ABC**
- Addictions Behavior Checklist (Compton, Wu, Schieffer, & Naliboff, 2008; Wu et al., 2006)
- Designed to identify observable behaviors characteristic of addiction related to prescription opioid medications in chronic pain populations during and/or between clinic visits.

**CAGE**
- Cut down, Annoyed, Guilty, Eye-opener for alcohol
- Adapted to include drugs (Brown & Rounds, 1995)

**DAST**
- Drug Abuse Screening Test (Skinner, 1982)
- 28-item self-report screening test that quantifies problems related to drug misuse.

**COMM**
- Current opioid misuse measure (Butler, et al., 2007)
- Monitoring during chronic opioid therapy.

**COWS**
- Clinical Opiate Withdrawal Scale (Wesson & Ling, 2003)
- A clinician-administered, pen and paper instrument that rates eleven common opiate withdrawal signs or symptoms.

**CRAFFT**
- (Knight et al., 1999)
- 6 questions for adolescents similar to CAGE asking about drug and alcohol.

**DIRE**
- Diagnosis, Intractability, Risks, and Efficacy (Belgrade, Schamber, & Lindgren, 2004)
- Quick assessment tool used and filled out by the healthcare provider to determine if they are appropriate for chronic opioid therapy.

**DUSI-R**
- Drug Abuse Screening Inventory (revised) (Tarter & Kirisci, 2001)
- Adolescent drug alcohol use, adverse outcomes mental health, and lie scale.

**ORT**
- Opioid Risk Tool (Webster & Webster, 2005)
- For lower risk patients to determine if appropriate for opioid use.

**PESQ**
- Personal Experience Screening Questionnaire (Winters, 1992)
- Quick questionnaire identifying adolescent drug abuse for referral to substance abuse treatment.

**PDUQ**
- Prescription Drug Use Questionnaire (Compton Darakjian, & Miotto, 1998)
- Comprehensive for addiction or problematic drug use.

**POSIT**
- Problem Oriented Screening Instrument for Teenagers (Latimer, Winters, & Stinchfield, 1997)
- Assessment of adolescent drug abuse.

**SOAPP**
- Screener and Opioid Assessment for Persons in Pain (Butler, Budman, Fernandez, & Jamison, 2004)
- For higher risk patients. Appropriateness for opioid therapy or misuse.

**TICS**
- Two-Item Conjoint Screen (Brown, Leonard, Saunders, Papasouliotis, 2001)
- A two-item conjoint screen for alcohol and other drug abuse or dependence.

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**Formal Assessment Tools & Standard Procedures**

- **CAUTION:**
  - Clinical judgment, diagnostic skills and a therapeutic relationship remain primary.
  - Tools and procedures cannot substitute for them.
  - UDT requires thorough understanding.
    - Can be misinterpreted.
    - Can lead to inappropriate exclusion of patients from legitimate pain management.

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**Recommendations Moderate Risk**

- **Follow Recommendations for All Patients**
- **Maximize**
  - nonopioid medications
  - nonpharmacologic approaches
  - interventional pain control methods
- **Do not substitute benzodiazepines, phenothiazines, antihistamines, or other sedating medications for analgesics.**
Recommendations
Moderate Risk

- Physically dependent patients on morphine-like opioids—
  - do not treat pain with an opioid partial agonist or agonist-antagonist,
  - may precipitate acute withdrawal.
- Opioids, benzodiazepines
  - taper slowly to minimize the emergence of withdrawal symptoms.

Recommendations
Moderate Risk

- Patients in recovery from a SUD:
  - Assess length and stability of recovery
  - Encourage active participation in recovery efforts
  - Identify stressors for relapse
    - Unrelieved pain
    - Open communication
    - treatment
    - potential relapse

Recommendations
Moderate Risk

If patient declines the use of opioids or other psychoactive medications, offer other available methods of pain relief.

Establish a therapeutic plan for relapse. If relapse occurs, intensify recovery efforts and assessments. Do not automatically terminate care.
Conduct thorough assessment:
- diagnoses of pain
- concurrent psychiatric conditions
- and substance use

Involves pain specialist and addiction specialist when possible.

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**Recommendations—Moderate Risk (Inpatient Acute Care)**

- Evaluate addiction risk
  - patterns gathered from multiple sources,
  - recurrent hospitalizations,
  - multiple prescribers,
  - inconsistent medical follow-up,
  - prescription monitoring programs,
  - discussions with primary care provider
- Maximize multimodal analgesia
  - opioids
  - nonopioids
  - local anesthetics

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**Recommendations—Moderate Risk (Inpatient Acute Care)**

- Formulate and educate re: patient discharge plan
- Adherence monitoring for outpatient meds
- Appropriate weaning of opioids if necessary
  - prevent withdrawal
- Consider referral to emotional-expressive therapy.
Recommendations-Moderate Risk (Inpatient Acute Care) Methadone

- Patient consent
- Confirm Outpatient Dose
- Do not rely on methadone for analgesia
- For IV
- equianalgesic opioid titration

Maximize ALL analgesic interventions → Higher than usual opioid doses (caution)

Recommendations-Moderate Risk (Inpatient Acute Care) Buprenorphine

(note: clinical evidence is limited)

Consultation recommended with a specialist knowledgeable and experienced with buprenorphine

- unique characteristics of the medication
- possible serious side effects or inadequate analgesia.

Recommendations-Moderate Risk (Inpatient Acute Care)

- Buprenorphine: high affinity for mu opioid receptor
- Compete with other mu opioids given concurrently, which may lead to:
  - Inadequate analgesia by blocking effect of mu opioids.
  - Opioid overdose: when buprenorphine plasma level declines with concurrent mu opioids.
Recommendations - Moderate Risk
(Inpatient Acute Care)

- **Buprenorphine**
  - Monitor for opioid withdrawal or opioid overdose and treat
  - Maximize non-opioid medications, Local, Regional, Spinal
  - Recommend discontinuing 48 hours before painful elective procedures & administer traditional opioids, non-opioids

For elective procedures (mild to moderate pain):
- Titrated upward for increased analgesia
- Or continue at low doses without interference

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Recommendations - Moderate Risk
(Inpatient Acute Care)

**Naltrexone** is a long-acting mu opioid antagonist used in treatment of alcohol and opioid substance use disorders
- Duration of action 24 hours to 4 weeks
- Consultation recommended with specialists knowledgeable in addiction and pain management.
- **Therapy should not be initiated until patient is opioid free for 7-10 days.

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Recommendations - Moderate Risk
(Inpatient Acute Care)

- Inadequate analgesia.
- Withdrawal syndrome.
- Overdose as the naltrexone plasma levels ↓
- Maximize nonopioid medications, i.e. local, regional, or spinal routes.
- If opioids are resumed after discontinuing naltrexone treatment, start at low doses and titrate carefully as needed

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When the Risk is **HIGH**

**Recognizing:**
- Active substance use disorder or aberrant behaviors
- Active addiction
- Major untreated psychiatric disorder

When the risk is **HIGH**

**Treatment:**
- Recommended management by pain management and addiction specialists as needed
- Frequent adherence monitoring (weekly or monthly)

When the risk is **HIGH**

**Remember:**
- Utilize the recommendations for ALL patients and also those for patients at moderate risk.
- Assess for withdrawal from alcohol and other drugs
Inappropriate Use

If inappropriate use of prescribed or illicit substances is suspected or confirmed—

• Provide a **therapeutic environment** to:
  ▪ Openly discuss patient and healthcare provider concerns.
  ▪ Modify treatment plan as needed, considering both safety and analgesic needs.
  ▪ Intensify monitoring of prescribed medications.

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Therapeutic Environment (cont.)

- Reduce number of pills per prescription.
- Shorten refill intervals.
- More frequent office visits, including daily prescriptions if needed.

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Therapeutic Environment (cont.)

- Solicit family/significant-other assistance in medication management.
- Consider formulations that are less likely to be misused.
- Consider inpatient treatment for addiction as indicated.
And finally,

**When the risk is HIGH**

- Consider eliminating opioid treatment for patients refusing further evaluation and treatment for a substance use disorder.
- Taper opioids, monitor for abstinence syndrome and promptly treat withdrawal.

"Patient centered care"

Patients with substance use disorders and pain have the right to be treated with dignity, respect, and the same quality of pain assessment and management as all other patients.

Knowing is not enough, we must apply. Willing is not enough, we must do.

-Goethe