Caring for the Patient with Co-morbid Diagnoses of Pain and Substance Abuse

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Pain

“An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in term of such damage.” (IASP definition)

“Pain is whatever the experiencing person says it is, existing whenever he says it does.” (McCaffery, 1968)

Prevalence of Chronic Pain

20% to 30% Of World Population

Addiction

"A primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations."

ASAM, APS, AAPM, 2001

Types of Addictions
Addiction vs. Diversion

- Neurobiological disease
- Clinical diagnosis
- Compulsive use
- Craving
- Continued use despite harm
- Impaired control over use

- Act of obtaining medications for purpose other than intended by clinician.
- For abuse
- For profit
- Criminal act

Physical Dependence

"State of physiological adaptation, in which a withdrawal syndrome occurs with abrupt cessation of a drug, rapid dose reduction, declining blood levels, or administration of an antagonist."

- Withdrawal may increase chronic pain.
- Tolerance develops with use.

Pseudo-addiction

Set of behaviors exhibited to obtain medication for adequate analgesia

Demanding & manipulative behaviors exhibited by patients when the opioid doses are not adequate for analgesia.

Behaviors are generally eliminated with appropriate dosing.

Weissman & Haddox, 1989

Quick Quiz
Chronic Pain, Addiction, or Both?

- Which is a disease?
- Which is “a chronic relapsing condition”?
- Which is disabling?
- Which is a primary illness?
- Which is **NOT** a character flaw?
- Which results in human suffering?

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Pain – Addiction Relationship

- **#1** reason for addiction is: self-medicating pain.
- Addiction is pain.
- Can **not** treat addiction, unless pain is treated first.
Co-morbidity Pain & Addiction

- Pain of any type or duration is reported by 80% of MMTP patients & 78% of inpatients.
- Chronic severe pain is experienced by 37% of MMTP patients & 24% of inpatients.
- Among those with chronic severe pain, 65% of MMTP patients & 48% of inpatients reported high levels of pain-related interference in physical and psychosocial functioning.


Controlling Pain in Patients Who also Have Diagnosis of Addiction or Substance Abuse/Misuse
Passik et al Study

- Goal: ID aberrant opioid use among those with and those without SA histories
- Found those w/ SA histories demonstrated more:
  - symptoms regarding pain
  - distress associated with pain
  - interference from residual pain
  - Opioid related behaviors that were problematic
- Concluded treating pain + SA requires skill and better approaches

(Passik, et al, 2006)

TROUP Study

- Two populations between 2000 – 2005
  - National commercially insured population
  - Arkansas Medicaid population
- 2000 – 2005 greater increase in all groups
- Rates doubled with additional pain diagnosis


Veterans Studies

- Aberrant behaviors
  - Sharing prescription medications (16.3%)
  - Using ETOH or street drugs (28.9%)
  - Combination of behaviors (35.3%)

(Dechet, et al, 2011)
- 8,224 Veterans HCV+
  - 67% documented pain and 56% SUD
  - 29% opioids year 1; 46% opioids year 3
  - Which group had 2.6 vs 5.3 days early refills?

**Substance Use, Misuse & Abuse in Older Adults**

- “Hidden Plague” “Invisible Epidemic”
- 2008 ~ 11% of older women misused Rx opioids
- Steady increases in admissions of OAs for SA issues
- Estimated that in 2020 there will be 5 million older adults w SA issues
  (Fleming et al, 1999; Quinlan-Colwell, 2011; Simoni-Wastila, et al, 2006; USDHHS, 2005)

**Paradigm Shift**

**Shifting the Paradigm**

- Chronic Pain & Addiction = primary illnesses.
- People with addictions & substance abuse disorders DO have pain.
- Acute Pain is a *symptom*.
- Opioids CAN be used **SAFELY**.
- Aggressive pain management is integral to effective addiction treatment.
“When addictive disease coexists with chronic pain, the pain must be treated first.”


Challenges of Managing Pain in Patients with Comorbid Dx

- Awareness
- Attitude
- Accurate identification (those w/ SA or at risk of developing SA)
- Adequate management of pain
- Appropriate management of SA

Awareness
Attitude

- Addiction is an illness
- No one selects to be addicted
- Challenge:
  - Replace "drug seeking"
  - With "Comfort Seeking" (Susan O’Donne-Van, 2012)

Assessment

Screening of Risk
Dunbar & Katz Study
- Goal: Identify factors associated with Rx abuse
- Less likely to abuse Rx opioids
  - H/o alcohol alone
  - Remote h/o polysubstance abuse
  - Stable support system (family, AA, other)
- More likely to abuse Rx opioids
  - Recent or active polysubstance abuse
  - No AA memberships
  - Oxycodone abuse hx

(Dunbar & Katz, 1996)

Opioid Assessment for Patients with Pain (SOAPP)
- Designed
  - By expert panel
  - To assess suitability of long term opioid therapy
- 14 item self report Likert scale tool
- Items are correlational not causative

(Passik, Kish, Casper, 2008)
**Diagnosis, Intractability, Risk and Efficacy Score (DIRE)**

- Designed to ID NCP patients at risk for opioid abuse
- Clinician administered
- 5 pointed questions
- Validated to differentiate SA from non-SA

**Opioid Risk Tool (ORT)**

- Score the tool that applies:
  - Family history of substance abuse
    - Alcohol
    - Illegal drugs
    - Prescription drugs
  - Personal history of substance abuse
    - Alcohol
    - Illegal drugs
    - Prescription drugs
  - Age (must be between 18-45 years)
  - History of recent violent assault
  - Psychiatric disorder
    - ADHD, ODD, Tourette, schizoaffective
    - Depression
  - Scoring Table

**Screening Instrument for SA Potential (SISAP)**

- Designed to ID NCP patients at risk for opioid abuse
- Clinician administered
- 5 pointed questions
- Validated to differentiate SA from non-SA
Screening Tool for Addiction Risk (STAR)

- Screens for addiction risk
- 14 questions (yes or no)
- Testing done but more is needed

(Passik, Kraf, Casper, 2008)

Signs of SA in Older Adults

- Disturbed sleep
- Cognitive problems (confusion, slurred speech)
- Changes in mood or disposition including anxiety, irritability, depression, restlessness, agitation
- Poor hygiene
- Falling and injuries
- Persistent concern about pain medications
- Problems in relationships

(Culberson & Ziska, 2008; Goldberg, 2008; US DHHS, 2001)

Assess for Other Substances

- Alcohol
- Sedatives
- Benzodiazepines
- Illegal Substances
Assessment of Pain

Pain is a Symptom!
Assess underlying pathology
- maintain open mind
- listen to all information

Need accurate information (hx & cc)
Need accurate analgesia history
- create safe environment
- create non-judgmental environment
- listen to all information

Universal Precautions

1) Careful assessment of risk for opioid abuse
2) Select most appropriate opioid therapy
3) Regular monitoring to evaluate:
   - efficacy & tolerability of therapy
   - for possible aberrant behaviors
4) Map solutions if abuse, addiction or treatment failure occur

(Webster & Fnc, 2010)

Treatment Contracts

- Benefits
- Contract itself not a predictor of success
  (Durbair, 1996)
- Convey mistrust
Urine Screening
- Intention for screening
- Documentation
- Follow up of testing
- Outcome Measurement and Quality
  (Passik, Schreiber, Kirsh, & Portnoy, 2000)

Avoid Withdrawal
- Up to 57% continued use because of fear of withdrawal
  (Gandey, 2010)
- Plan for discontinuation
- Prescribe titration
- Reasonable expectations

Multimodal Analgesia
Why use multiple methods?

Combining medications with different mechanisms of action & different side effects.

Less of each medication is used.
Benefit is maximized!
Side effects are minimized.

Pain is a SYMPTOM
Target the cause
Consider the specific type of pain being treated.
Non-Opioid Analgesia
- Acetaminophen
- NSAIDS
- Adjuvant agents

Epidural or Regional Analgesia
- Intra-operative
- Post-operative
  - Continuous infusion
  - PCEA or PCRA
- Infusion
  - Opioid
  - Local anesthetic
  - Combination

Topical Agents
- Local anesthetic
- NSAIDS
- Compounded agents
Opioid Analgesia

- Cornerstone of management of moderate to severe pain

Delivery of Opioids

- Continuous or sustained release
- Scheduled vs prn
- Pre-emptive analgesia
- PCA
  - mixed empirical data
  - increases control
  - reduces anxiety

(Alford, et al., 2006)

Case Study

I.R.
I. R.

- 51 y/o
- restrained driver in single car MVA

PMH:
- emphysema r/t tobacco abuse
- IVDA (heroin)

Please, Write down your description of IR.

I. R.

- 51 y/o Caucasian female
- actual body weight 50 kg
- restrained driver in single car MVA

PMH:
- breast CA with mets to bone BLE & thorax
- emphysema r/t tobacco abuse
- IVDA (heroin)
I. R. pre admit meds

- Methadone 90 mg qd x 20 years
- MS contin 30 mg tid x 6 years
- Percocet 2 q 4 hrs prn pain (average 12 per day)

I. R. analgesia post admission

Morphine PCA:
- 4mg PCA dose
- 8 min LO
- 0 4 hour max

Pain Consult

- Pain 11/10
- Assessed
- Started:
  - Dilaudid PCA
    - Loading Dose of 2 mg then
    - PCA doses of 0.1/8/0
  - Ketorolac
    - 30 mg stat
    - 15 mg q 6 hrs x 24
### Dilaudid

<table>
<thead>
<tr>
<th>Day</th>
<th>Pain</th>
<th>Dose</th>
<th>Used</th>
<th>Adjuvant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11/10</td>
<td>1</td>
<td>Q 8 min</td>
<td>Ketorolac, Methadone 90 mg/ qd</td>
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<tr>
<td>2</td>
<td>5/10</td>
<td>1.4</td>
<td>Q 8 min</td>
<td>Ketorolac, Ativan Methadone 90 mg/ qd</td>
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<tr>
<td>3</td>
<td>5/10</td>
<td>1.5</td>
<td>Q 8 min</td>
<td>Ativan Methadone 90 mg/ qd</td>
</tr>
<tr>
<td>4</td>
<td>1-2/10</td>
<td>1.2</td>
<td>Q 8 min</td>
<td>Ativan Methadone 90 mg/ qd</td>
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### Dilaudid

<table>
<thead>
<tr>
<th>Day</th>
<th>Pain</th>
<th>Dose</th>
<th>Used</th>
<th>Adjuvant</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>3/10</td>
<td>1.2</td>
<td>Q 8 min</td>
<td>Vioxx, Ativan Methadone 90 mg/ qd</td>
</tr>
<tr>
<td>6</td>
<td>4-6/10</td>
<td>0.8</td>
<td>Q 8 min</td>
<td>Vioxx, Ativan Methadone 90 mg/ qd</td>
</tr>
<tr>
<td>7</td>
<td>2/10</td>
<td>0.6</td>
<td>Q 8 min</td>
<td>Vioxx, Ativan Methadone 90 mg/ qd</td>
</tr>
<tr>
<td>8</td>
<td>1-2/10</td>
<td>d/c</td>
<td>0</td>
<td>MS contin 15mg tid Methadone 90 mg/ qd</td>
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</table>

### Comparison of I.R. Opioids

<table>
<thead>
<tr>
<th>Medication</th>
<th>Pre MVA doses</th>
<th>Hospital D/C doses</th>
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</thead>
<tbody>
<tr>
<td>Methadone</td>
<td>90 mg daily</td>
<td>90 mg daily</td>
</tr>
<tr>
<td>MS Contin</td>
<td>30 mg tid</td>
<td>15mg tid</td>
</tr>
<tr>
<td>Percocet</td>
<td>2 q hrs (12/day)</td>
<td>none</td>
</tr>
</tbody>
</table>
Multidisciplinary Approach
- MMT Team
- Physicians
- Pain specialists
- Care Nurses
- Pharmacists
- Non-pharm – complementary providers
- Behavioral health

Caring Presence
- Centered place
- Compassion
- Intention to help
- Focused attention

Environmental Modifications
- hospital room = world
- position in their world
- temperature
- lighting
- quiet vs. sound/noise
- visitors vs. solitude
- activity vs. isolation
Non-pharm Interventions

- Breathing
- Relaxation Techniques
- Guided Imagery
Incite
Compassionate
Insight!