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

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### Abstract

The American Society for Pain Management Nursing (ASPMN) has updated its position statement on managing pain in patients with substance use disorders. This position statement is endorsed by the International Nurses Society on Addictions (IntNSA) and includes clinical practice recommendations based on current evidence. It is the position of ASPMN and IntNSA that every patient with pain, including those with substance use disorders, has the right to be treated with dignity, respect, and high quality pain assessment and management. Failure to identify and treat the concurrent conditions of pain and substance use disorders will compromise the ability to treat either condition effectively. Barriers to caring for these patients include stigmatization, misconceptions, and limited access to providers skilled in these two categories of disorders. Topics addressed in this position statement include the scope of substance use and related disorders, conceptual models of addiction, ethical considerations, addiction risk stratification, and clinical recommendations.

### Key or Search Terms

addiction; pain; opiate analgesics; position paper; substance use disorders

### Position Statement

ASPMN and IntNSA hold the position that 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. Safe and effective care of patients with substance use disorders includes maintaining a balance between the provision of pain relief, monitoring for appropriate use of prescribed medications and other substances, and recommendations for viable treatment alternatives. Nurses are well positioned and obligated to advocate for pain management across all treatment settings for patients at various points along a continuum of substance use.

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## Background

### Scope of Substance Use and Related Disorders

**Prevalence**—Substance use and related disorders are common in our society. Illicit use of controlled substances is a leading category of medication misuse. In 2009, the number of Americans reporting current nonmedical use of prescription drugs exceeded the number using cocaine, heroin, hallucinogens, and inhalants combined (SAMHSA, 2010a). According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2011), in 2010, an estimated 22.6 million Americans (8.9% of the population) aged 12 or older reported using an illicit substance in the previous month. Approximately 7 million of these individuals met diagnostic criteria for a drug use disorder, and an estimated 5.1 million persons reported they had used prescription pain relievers in a nonmedical or non-prescribed manner. Sixty-six percent of those individuals obtained these medications from a friend or relative, and nearly 80% of those friends or family members had each obtained their medications from a single prescriber. More than a third of those who had used these medications illicitly (1.9million persons) were classified as having abused or been dependent upon these substances (SAMHSA, 2011).

In the pediatric population, prescription opioids are the most commonly used drugs for nonmedical purposes. Too often children and youths mistakenly assume that prescription medications are safer than street drugs to relieve discomfort or to feel good. Nonmedical users can be divided into two distinct groups of self-treatment versus other reasons for use. In a study of adolescents by Boyd, McCabe, Cranford, and Young (2006), 69% reported pain control for complaints such as headache or menstrual cramps as the primary reason for nonmedical opioid use. This may be more appropriately viewed as self-medicating or opioid misuse, which is associated with a lower risk for subsequent opioid abuse or dependence. A small minority (11%) reported using prescription opioids solely to “get high.” The National Center on Addiction and Substance Abuse at Columbia University (CASA, 2011) has called adolescent substance misuse—including alcohol, tobacco, and other drugs—the nation’s number one health problem. The number of high school students who reported ever having misused opioids increased significantly between the beginning (8.3 % of 9th graders) and end of high school (16.3 % of 12th graders), with nearly 13% having misused prescription opioids in their lifetime, and 3.4 % currently misusing these substances (CASA, 2011; Frese & Eiden, 2011). Diversion of prescription opioids is also common among pediatric nonmedical users. A full 75% of youths report borrowing medications from family or friends instead of seeing a healthcare provider.

Although sometimes overlooked, abuse/misuse of prescribed medications occurs in all ages, including middle aged and older adults. Additionally, as the population ages, experts predict that prescription drug abuse among the elderly will also rise significantly (Martin, 2008). In people aged 50 or older, an increase of up to 190% in nonmedical use of psychotherapeutic drugs is projected over two decades from 911,000 in 2001 up to 2.7 million in 2020 (Colliver, Compton, Gfroerer, & Condon, 2006).

Over the past decade, there have been steadily rising rates of hospital admissions for the treatment of prescription opioid misuse. Visits to hospital emergency departments (ED) involving the nonmedical use of prescription analgesics rose 111 %, more than doubling the number of visits between 2004 and 2008. The top three medications mentioned in these visits were oxycodone, hydrocodone, and methadone products (SAMHSA, 2010b). Additionally, unintentional deaths related to opioids have reached epidemic proportions (Center for Disease Control and Prevention, 2010; Morbidity and Mortality Weekly Report, 2011). The risk of death is magnified when opioids are taken in combination with alcohol, sedatives, hypnotics, and anxiolytics.

**Financial impact**—The total cost of substance use to federal, state, and local governments is estimated to be a staggering \$467.7 billion per year (CASA, 2011). The National Prescription Drug Threat Assessment survey found controlled prescription diversion (CPD) occurs most often through doctor-shopping, prescription fraud, and theft (National Drug Intelligence Center [NDIC], 2010). The estimated cost of controlled prescription diversion is \$72.5 billion a year to public and private medical insurers, and this cost is passed on to consumers through higher health insurance premiums. In an effort to address some of these problems, prescription monitoring programs (PMPs) have been established in the majority of states, although no such national system currently exists. PMPs have been shown to reduce the number of prescriptions illicitly obtained through doctor-shopping (NDIC, 2010).

**Implications for healthcare**—In examining the intersection of persistent pain and addiction, problematic drug-taking behaviors have been identified in up to 40% of all pain patients; much fewer appear to actually have a substance use disorder. An estimated 20% of those individuals demonstrated behaviors suggestive of substance abuse, while only 2–5% demonstrated behaviors indicative of the disease of addiction (Webster & Webster, 2005). Failure to identify and treat the concurrent condition of pain and addiction will compromise the ability to treat either condition effectively (Gourlay, Heit & Almahrezi, 2005). The nurse's role is to advocate for the individual needs of the pain patient in the context of substance use disorders. Nurses and other healthcare providers may have personal beliefs and experiences that can negatively impact the ability to provide effective care for patients who have both substance use disorders, including those with pain. All interdisciplinary healthcare team members are encouraged to engage in therapeutic discussions with each other to openly explore beliefs and attitudes regarding these conditions (McCaffery, Grimm, Pasero, Ferrell, & Uman, 2005).

### Barriers to Care

**Stigma**—Stigma is rooted in shame and guilt, and interferes with the development of trust, and the establishment of a therapeutic relationship. When patients feel stigmatized, they are more likely to hide an addiction (Arnstein, 2010; McCaffrey, 2011). The use of stigmatizing terms, such as *drug-seeking*, creates prejudice and promotes a shame-based context of care (McCaffery, et al., 2005). Other stigmatizing terms include *junkie*, *addict*, or *dirty* versus *clean* urine drug tests (UDT). Preferred terms that promote an understanding of addiction as a medical condition include *people with substance use disorders*, *active addiction*, and *positive* or *negative* urine drug tests.

An inadequate understanding or punitive application of certain aspects of adherence monitoring, such as urine drug testing and pill counts, can also stigmatize patients, and exclude them from an otherwise full array of pain management options. The nurse's role in reducing and eliminating stigma is to develop a rapport with the patient and family, educate them regarding the disease model of addiction, and provide reasonable alternatives when opioids are declined or deemed inappropriate.

**Common misconceptions**—A number of common misconceptions exist regarding pain and substance use disorders or addiction. These misconceptions can occur among clinicians as well as patients, families, and the public, and may result in negative interactions, assessments, treatment and outcomes. Table 1 lists a number of these misconceptions, along with their respective corrections.

## Conceptual Models

There are a number of conceptual models, including those that are evidence-based, which frame our understanding of addiction and shape the direction of treatment. These models are not mutually exclusive and may overlap.

1. **Moral and criminal models** of addiction assume a flawed character, lack of willpower, and volitional aspects to what are considered to be socially unacceptable or deviant behaviors. Treatment strategies are often aimed at punishment (i.e., incarceration), isolation, and rehabilitation. These models convey erroneous messages of blame and shame to individuals with addictive disorders (Lee, Lee, & Lee, 2010; Morse, 2004).
2. The **12-step model** describes addictive behaviors as symptoms of an underlying spiritual crisis, with personal isolation from one's own values contributing to emotional upheaval. Addressing individual powerlessness over addictive behaviors, followed by continued personal and group involvement, incorporating the 12-step principles into daily life, is considered the foundation to spiritual awakening and behavioral change (Halstead & Matthew, 2003).
3. The **disease model** recognizes, substance abuse disorders, and addiction as chronic illnesses. Addiction is viewed as 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 & Peselow, 2009).
4. The **bio-psycho-social-spiritual model** views 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. Through treatment and recovery, biological, psychological, sociocultural and spiritual processes interact to synergistically preserve, resume, or establish integration and wholeness within the individual.

## Definitions

There is a decided lack of consensus about the way that terminology is used to describe substance use, substance use disorders, and addiction. Nomenclature is often inconsistent, inaccurate, and confusing, reflecting, at least in part, the diverse perspectives of those working in various, related fields, including healthcare, law enforcement, regulatory agencies, and reimbursement/payer organizations. While signs and symptoms may overlap, it is imperative to distinguish between tolerance, withdrawal, physiological dependence, and pseudoaddiction, in contrast to substance use disorders and addiction, and to use accurate and non-pejorative language.

At the time of this writing (2012), diagnostic criteria for substance use disorders were in accordance with the American Psychiatric Association (2000), *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR). 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*.

## Addiction

A chronic, relapsing, treatable disease of the brain characterized by craving, dysfunctional behaviors, and an inability to control impulses regarding consumption of a substance with compulsive use despite harmful consequences. More recently, the American Society of Addiction Medicine (ASAM) defines addiction as a primary, chronic disease of brain

reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

**Diversion**

Redirecting drugs from their lawful medical purpose for illicit use, distribution, or sale (Caplan, Gourlay, & Heit, 2004; Katz, et al., 2007).

**Physical Dependence**

An expected physical response to a number of drug classes (such as opioids and benzodiazepines) that produces a drug-class specific withdrawal/abstinence syndrome, with specific symptoms, precipitated by an abrupt cessation, rapid dose reduction, decreasing blood levels of the drug, and/or the administration of an antagonist (American Academy of Pain Medicine [AAPM;2001]).

**Pseudoaddiction**

An iatrogenic syndrome associated with the under-treatment of pain; characterized by various problematic behaviors that appear abuse-like. Pseudoaddiction can be distinguished from true addiction in that the behaviors resolve when pain is effectively treated (Weissman & Haddox, 1989). Alternatively, Alford, Compton, and Samet (2006) define this as “behavioral changes in patients that seem similar to those in patients with opioid dependence or addiction but are secondary to inadequate pain control” (p. 128).

**Recovery**

“The experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life” (White, 2007, p.236).

**Relapse**

A construct derived from the chronic disease model suggesting return to a more active disease state with resumption of alcohol or drug use due to impaired control and/or craving after a period of abstinence (McLellan, Lewis, O'Brien, & Kleber, 2000).

**Risk Stratification**

The process by which patients with pain are screened and evaluated in terms of their risk for developing an addictive disorder or diversion of controlled medications. Behavioral assessments, patient/family histories of substance abuse, psychological evaluations, standardized screening tools (see recommendations and Appendix A), and adherence monitoring strategies are useful in determining risk and treatment planning. (Chou, Fanciullo, Fine, Adler, Ballantyne, Davis, ... Todd, 2009).

**Slip/Lapse**

A brief or circumscribed return to substance use or activity by someone who was abstinent from that substance use or activity.

**Spirituality**

The essence of an individual's being, which permeates living and infuses an unfolding awareness of who and what they are, their purpose in being, their inner resources, and shapes their life journey (Sorajjakool, Thompson, Aveling, & Earl, 2006).

**Substance abuse**

Criteria for a diagnosis of substance abuse, as described in DSM-IV-TR, include a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by a recurrence of one or more of the following within the same 12-month period: (1) failure to fulfill major role obligations, (2) use in physically hazardous situations, (3) legal problems, and/or (4) continued use despite social or interpersonal problems resulting from use (APA, 2000).

**Substance dependence**

Criteria for a diagnosis of substance dependence, as described in DSM-IV-TR, include a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following within the same 12-month period: (1) tolerance, (2) withdrawal, (3) loss of control over use, (4) inability to cut down or control use, (5) a great deal of time spent to obtain, use, or recover from the effects of a substance, (6) other important activities are given up or reduced, and/or (7) continued use despite continued negative consequences (APA, 2000).

**Substance misuse**

The use of any drug in a manner other than how it is indicated, intended, or prescribed (Jamison, et al., 2010).

**Substance use disorder**

In DSM-IV-TR, substance use disorders include the diagnoses of substance abuse and substance dependence (APA, 2000). It is anticipated that DSM 5 will refer more broadly to substance use disorders, which are then further delineated as moderate or severe (APA, 2010).

**Tolerance**

A state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time (AAPM, 2001).

**Universal Precautions**

Recommendations to guide assessment and management of persistent pain with a triage scheme for estimating risk of addiction in order to improve patient care, reduce stigma, and contain risk (Gourlay, Heit, & Caplan, 2006). See Recommendations for All Patients, below.

**Ethical Tenets**

A dynamic tension and therapeutic balance exists between a patient's need for pain relief and concerns about potential medication misuse and harmful consequences to themselves or others. The World Health Organization (WHO) has declared relief of pain to be a



fundamental human right (Green, Todd, Lebovits, & Francis, 2006). Failure to treat pain is “an unethical breach of human rights” (Brennen, Carr, & Cousins, 2007). The Declaration of Montreal (2010) recognizes, “the intrinsic dignity of all persons and that withholding of pain treatment is profoundly wrong, leading to unnecessary suffering which is harmful.” Multiple ethical principles apply to pain management for patients across a continuum of substance use (see Table 2).

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. Nurses have ethical obligations to:

- evaluate and treat problems associated with unrelieved 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, and
- advocate for holistic treatment of patients with pain and substance use disorders.

## Recommendations

Table 3 describes categories to assist the healthcare provider to assess for the risk of concurrent addictive disease in patients with persistent pain. Table 4 provides the healthcare provider assistance in evaluating pediatric patients for the risk of nonmedical opioid use and abuse/dependence.

### Recommendations for ALL patients, including those assessed to be at low, moderate or high risk for addiction

- I. Utilize 10-Step Universal Precautions approach for patients with persistent pain (Gourlay, et al., 2005).
  - A. Make a pain diagnosis with appropriate differential
  - B. Psychological assessment, including risk of addictive disorder
 

*Explanation:* Respectful risk assessment does not diminish a patient’s complaint of pain.

*Explanation:* Discuss adherence monitoring with all patients.

    1. Offer further assessment for possible substance use disorder for patients found with illicit or non-prescribed licit substances on urine drug testing (UDT).
    2. Controlled substances may be unsafe for patients refusing further assessment. Offer alternative non-opioid treatment and therapies with appropriate opioid weaning as needed to avoid withdrawal.
  - C. Informed consent
 

*Explanation:* Discuss with the patient and answer any questions regarding anticipated benefits and risks of proposed treatment plan.
  - D. Treatment agreement
 

*Explanation:* A carefully worded treatment agreement with mutually agreed upon goals will help to clarify appropriate boundaries, facilitate

early identification and response to non-adherent behaviors, and include an exit strategy for possible cessation of opioid therapy.

**E.** Pre/post intervention assessment of pain level and function

*Explanation:* Evaluation of the success or failure to meet agreed upon goals is essential to support continuation or change in the treatment plan.

**F.** Appropriate trial of opioid therapy with or without adjunctive medication

*Explanation:* Use of a pharmacologic regimen must recognize that opioids are not routinely the treatment of first choice or of last resort, and should consider an individualized combination of opioids and adjunctive medications.

**G.** Reassessment of pain level and level of functioning

*Explanation:* Regular reassessment along with confirmation from family/significant others will help support rationale for continuation or change of treatment. High self reported pain scores are commonly seen in persons with persistent pain on opioids. Scores are often high because of distress factors that relate to patient anticipation that medication is continued only when scoring pain as high. A decision to advance opioid dosing, should not be based solely on pain scores, but should include a comprehensive functional assessment (Treisman & Clark, 2011).

**H.** Regularly assess the “Five A’s” of pain medicine: Analgesia, Activity, Adverse effects, Aberrant behavior, and Affect (adapted from Passik & Weinreb, 2000).

*Explanation:* Comprehensive assessments help direct therapy and support pharmacologic options.

**I.** Periodically review pain diagnosis, coexisting conditions, including the presence of a substance use disorder, and treatment plan

*Explanation:* In the pain and addiction continuum, patients may move from dominance of one condition to another requiring a change in treatment focus. “If an addictive disorder dominates, aggressive treatment of an underlying pain problem will likely fail if not coordinated with treatment for the concurrent addictive disorder” (Gourlay, et al., 2005, p. 110).

**J.** Documentation

*Explanation:* Thorough documentation along with a therapeutic relationship with the provider will:

1. Facilitate communication with the patient and other providers.
2. Allow evaluation of clinical outcomes and further treatment planning.
3. Reduce medical-legal liability.

**II.** Consider multimodal and integrative therapy options. This may include multimodal pharmacotherapy, interventional techniques such as nerve blocks, psychological/psychiatric support, coping skills enhancement, spirituality, 12-step programs, family involvement/support, physical/occupational therapy, and complementary/alternative therapies such as acupuncture or mindfulness-based approaches.



- III.** Formal assessment tools and standard procedures are encouraged to guide individualized care and to limit legal liability (See Appendix A).
  - A.** Adherence monitoring procedures may include pill counts, urine toxicology studies, and use of prescription monitoring programs in the context of thoughtful clinical consideration of patient's best interest.
  - B.** A thorough understanding of urine drug testing is necessary to avoid misinterpretation of test results and an inappropriate exclusion of patients from legitimate pain management (Heit & Lipman, 2009).

CAUTION: Care must be taken not to use these tools and procedures as a substitute for the caregiver's clinical judgment and diagnostic skills, nor disrupt the therapeutic relationship between patient and caregiver (Gourlay, et al., 2004).

### **Recommendations for patients at MODERATE risk (Refer to Table 3)**

- I.** Utilize recommendations for ALL patients.
- II.** Maximize appropriate non-opioid medications, nonpharmacological, and interventional pain control methods.
- III.** Do not substitute benzodiazepines, phenothiazines, antihistamines or other sedating medications for analgesics.
- IV.** If the patient is physically dependent on morphine-like opioids, do not treat pain with an opioid partial agonist or agonist-antagonist, e.g., nalbuphine, butorphanol, buprenorphine, pentazocine, as it may precipitate acute withdrawal.
- V.** When opioids, benzodiazepines, or other medications with a potential for physical dependence are no longer needed, taper them slowly to minimize the emergence of withdrawal symptoms.
- VI.** For patients in recovery from a substance use disorder:
  - A.** Assess length and stability of recovery and encourage active participation in recovery efforts.
  - B.** Identify patient-specific stressors for relapse, including unrelieved pain.
  - C.** Encourage open communication with patient and significant others with concerns regarding treatment or potential relapse.
- VII.** If patient declines the use of opioids or other psychoactive medications, offer other available methods of pain relief.
- VIII.** Establish a therapeutic plan for relapse. If relapse occurs, intensify recovery efforts and assessments. Do not automatically terminate care.
- IX.** Additional recommendations for inpatient acute pain management:
  - A.** Involve pain specialist and addiction specialist if possible.
  - B.** Conduct a thorough assessment to establish diagnoses of pain, concurrent psychiatric conditions, and substance use.
  - C.** Evaluate addiction risk with watchful consideration for patterns gathered from multiple sources, including recurrent hospitalizations, multiple prescribers, inconsistent medical follow-up, prescription monitoring programs, and discussions with primary care provider.

- D.** Maximize multi-modal analgesia, including opioids, non-opioids, and local anesthetics, as well as alternative agents, including dexmedetomidine and ketamine.
1. See recommendations in item X. below for patients on methadone maintenance, buprenorphine, or naltrexone.
  2. Prudent use of short-acting opioids for initial acute pain control.
  3. Consider the use of intravenous (IV) or epidural patient-controlled analgesia (PCA) for short term analgesia, even for actively “using” patients, to promote steady analgesia and decrease sharp peaks in blood levels so as to minimize triggering the CNS reward system (Drew & St. Marie, 2011).
  4. Consider use of appropriate long-acting opioids for discharge analgesia, especially those with lower abuse potential (e.g., tamper resistant or abuse deterrent formulations including those with naltrexone or naloxone, or transdermal patches).
  5. Consider UDT during inpatient hospitalization as needed to monitor for use of outside substances.
  6. Formulate with and educate patient regarding discharge plan.
    - a. Ensure adherence monitoring for outpatient medications.
    - b. Appropriate weaning of opioids if necessary prior to discharge to prevent withdrawal.
    - c. Consider referral to emotional-expressive therapy.
- X.** Pain management for patients receiving pharmacotherapy for the disease of addiction:
- A.** Methadone:
1. Obtain patient consent and contact methadone maintenance treatment provider to confirm methadone dose and program compliance.
  2. Continue the confirmed methadone maintenance dose, but do not rely on it for analgesia.
  3. If unable to take oral methadone, recommend consultation with a pain specialist for equianalgesic opioid titration.
  4. Maximize non-opioid and nonpharmacological analgesic interventions.
  5. Add another opioid for analgesia and be prepared to administer doses higher than usual due to opioid tolerance.
- B.** Buprenorphine (Note: clinical evidence is limited in managing acute pain in patients receiving buprenorphine maintenance therapy):
1. Consultation recommended with a specialist knowledgeable and experienced with buprenorphine due to the unique

characteristics of the medication, and possible serious side effects or inadequate analgesia.

2. Buprenorphine has a high affinity for the mu opioid receptor and will compete with other opioids that are given concurrently, which may lead to:
  - a. Inadequate analgesia by blocking the effect of concurrent opioids.
  - b. Opioid overdose as the buprenorphine plasma level declines in the presence of significant concurrent opioids.
  - c. Acute opioid withdrawal syndrome as the buprenorphine plasma level declines in the presence of inadequate additional opioids.
3. Monitor for opioid withdrawal OR opioid overdose and treat appropriately.
4. Maximize non-opioid medications, including local anesthetics administered by local, regional or epidural routes.
5. Recommend discontinuing buprenorphine 48 hours prior to painful elective procedures, and administer traditional opioids and non-opioids as indicated for analgesia.
6. For elective procedures with anticipated mild to moderate pain, low dose buprenorphine oral tablets or transdermal patches may either be titrated upward for increased analgesia or may be continued at low dosages without interference with additional opioid analgesics.

#### C. Naltrexone:

1. Naltrexone is a long-acting mu opioid antagonist used in treatment of alcohol and opioid substance use disorders with duration of action ranging from 24 hours to 4 weeks, depending on dose and route of administration.
2. Consultation recommended with specialists knowledgeable in addiction and pain management.
3. Therapy should not be initiated until patient is opioid-free 7–10 days.
4. Naltrexone blocks the effects of concurrently administered opioids which may lead to:
  - a. Inadequate analgesia.
  - b. Opioid withdrawal syndrome.
  - c. Opioid overdose as the naltrexone plasma levels decrease.
  - d. Decreased opioid tolerance after discontinuation of naltrexone treatment, after a missed dose, or near the end of the dosing interval. This may increase the risk

of overdose with resumption of opioids at previously well-tolerated dosages.

5. Monitor for opioid withdrawal OR opioid overdose and treat appropriately.
6. Maximize non-opioid medications, including local anesthetics administered by local, regional or epidural routes.
7. If opioids are resumed after discontinuing naltrexone treatment, then start at low doses and titrate carefully as needed.

### **Recommendations for patients at HIGH risk (Refer to Table 3)**

- I. Utilize recommendations for ALL patients and MODERATE risk patients.
- II. Assess for withdrawal from alcohol or other drugs and refer for treatment as indicated.
- III. If inappropriate use of prescribed or illicit substances is suspected or confirmed, provide therapeutic environment to:
  - A. Openly discuss patient and healthcare provider concerns.
  - B. Modify treatment plan as needed, considering both safety and analgesic needs.
  - C. Intensify monitoring of prescribed medications.
  - D. Reduce number of pills per prescription.
  - E. Shorten refill intervals.
  - F. More frequent office visits, including daily prescriptions if needed.
  - G. Solicit family/significant other assistance in medication management. Consider formulations that are less likely to be misused.
  - H. Consider inpatient treatment for addiction as indicated.
- IV. 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.

### **Recommendations for nursing, prescribers, and institutions to optimize the care of patients with concomitant pain and substance use disorders**

#### **Nursing Practice—**

- Stay abreast of current knowledge in the evolving fields of pain management and substance use disorders.
- Advocate for best practices and provide nonbiased, evidence based care.
- Contribute through research, education, and clinical practice to the development of holistic nursing models.

#### **Prescriber/Provider Practice—**

- Remain up to date with an understanding of pain management and substance use disorders.

- Demonstrate and model best practices.
- Utilize safe prescribing protocols with options for individualization if needed.
- Refer for appropriate specialty care.
- Advocate as needed for this marginalized population.

#### **Institutional Recommendations—**

- Engage key stakeholders in the establishment of policies or protocols that ensure appropriate expertise, therapies, and resources are available.
- Convene clinical practice committees charged with reviewing the practice of nurses, pharmacists, physicians, and any provider caring for patients with persistent pain or substance use disorders.
- Call upon pharmacy and therapeutic committees to ensure optimal access to care.
- Institute quality assurance processes to monitor appropriateness and efficacy of care.

### **Summary**

An ethical imperative exists to provide safe and effective pain management to patients with substance use disorders. Healthcare professionals must not allow stigma and misconceptions to be barriers to the provision of compassionate and effective patientcentered care. Utilization of accurate knowledge and resources for pain management in patients with coexisting substance use disorders is paramount.

While addiction is a significant public health concern, so too is the under-treatment of pain. Sufficient evidence exists to show that stress from poorly treated pain may trigger relapse, or exacerbate an existing addiction. Patients with substance use disorders can and should be treated with dignity, respect, and the same quality of pain assessment and management as all other patients. Failure to identify and treat the concurrent condition of pain and substance use disorders will compromise the ability to treat either condition effectively.

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## Appendix A

### Examples of Risk Assessment Tools

See Appendix C for additional risk assessment resources

Acronym	Tool	Purpose of Tool
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 persistent pain populations during and/or between clinic visits.
CAGE	Cut down, Annoyed, Guilty, Eyeopener for alcohol	Quick assessments of alcohol and other substance dependence
CAGE AID	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 ongoing 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 ongoing opioid therapy.
DUSI-R	Drug Abuse Screening Inventory (revised) (Tarter & Kirisci, 2001)	Adolescent drug alcohol use, adverse outcomes mental health and "lie" scale to account for denial
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	Screeners 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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## Directory of Resources

The following information was current as of April 30, 2012 and is not an exhaustive listing. Identified resources are from professional organizations, academic institutions, and healthcare industry.

### Professional Societies

- American Academy of Pain Management (AAPM)
- American Academy of Pain Medicine
- American Association of Addiction Psychiatry (AAAP)
- American Holistic Nurses Association (AHNA)
- American Pain Society (APS)
- American Psychiatric Association (APA)
- American Society for Pain Management Nursing (ASPMN)
- American Society of Addiction Medicine (ASAM)

International Nurses Society on Addictions (IntNSA) International Society of Addiction Medicine (ISAM)

## Guidelines and Reports on Addictions and Pain Treatment

Agency for Healthcare Research and Quality National Guideline Clearinghouse <http://www.guideline.gov/browse/by-topic.aspx>

Agency Medical Directors Group <http://www.agencymeddirectors.wa.gov/guidelines.asp>

American Pain Society [http://www.ampainsoc.org/library/pdf/Opioid\\_Final\\_Evidence\\_Report.pdf](http://www.ampainsoc.org/library/pdf/Opioid_Final_Evidence_Report.pdf)

American Society of Addiction Medicine (ASAM) <http://www.asam.org/docs/public-policy-statements/1-counteract-drug-diversion-1-12.pdf>

Center for Disease Control and Prevention (CDC) <http://www.empr.com/cdc-issues-statement-and-recommendations-regarding-prescription-drug-misuse/article/171717/>

Federation of State Medical Boards [http://www.fsmb.org/pdf/2004\\_grpol\\_Controlled\\_Substances.pdf](http://www.fsmb.org/pdf/2004_grpol_Controlled_Substances.pdf)

National Institute of Drug Abuse (NIDA) <http://www.nida.nih.gov/tib/prescription.html>

National Institutes of Health National Institute on Drug Abuse (NIDA) <http://www.drugabuse.gov/publications/resource-guide>

Nurse Practitioner Healthcare Foundation [http://www.nphealthcarefoundation.org/programs/downloads/white\\_paper\\_opioids.pdf](http://www.nphealthcarefoundation.org/programs/downloads/white_paper_opioids.pdf)

PainEDU.org Improving Pain Treatment through Education <http://www.painedu.org>

National Center on Addiction and Substance Abuse at Columbia University (CASA) <http://www.casacolumbia.org>

SAMHSA <http://www.kap.samhsa.gov/products/manuals/tips/pdf/TIP54.pdf>

Utah Department of Health <http://www.health.utah.gov/prescription/tools.html>

US Department of Veterans Affairs <http://www.healthquality.va.gov>

## Informational Sites

Addiction Technology Transfer Center Network <http://www.attcnetwork.org>

Center for Substance Abuse Treatment (CSAT) <http://www.samhsa.gov/about/csat.aspx>

Emerging Solutions in Pain <http://www.emergingsolutionsinpain.com>

National Alliance of Methadone Advocates <http://www.methadone.org>

National Institutes of Health National Institute on Drug Abuse (NIDA) <http://www.drugabuse.gov>

Opioid Risk Skills to Minimize the Risk of Prescription Opioid Misuse <http://www.opioidrisk.com>



Pain Treatment Topics <http://pain-topics.org>

Substance Abuse and Mental Health Services Administration (SAMHSA) <http://www.samhsa.gov>

The National Addictions Vigilance Intervention and Prevention Program (NAVIPPRO) <http://www.navippro.com>

## Resources for Treatment Options

Addiction Survivors <http://www.addictionsurvivors.org>

Alcoholics Anonymous <http://www.alcoholics.anonymous.org>

Find Treatment.org <http://www.findtreatment.org>

Hazelden Information Center <http://www.hazelden.org> 24 hour hotline: 800-257-7810  
Publications: 800-328-9000

Narcotics Anonymous <http://www.na.org>

National Council on Alcoholism and Drug Dependence <http://www.ncadd.org>

National Institutes of Health National Institute on Drug Abuse (NIDA) <http://www.nih.gov/news/health/jan2012/nida-17.htm>

Opioids911-Safety <http://opioids911.org/>

Pain Treatment Topics <http://pain-topics.org>

[pain-topics.org](http://pain-topics.org) Painaction <http://painaction.com>

The National Alliance of Advocates for Buprenorphine Treatment <http://www.naabt.org>

**Table 1**

## Common Misconceptions with Correct Information

Misconception	Correction
Tolerance and withdrawal, or physiological dependence upon opioids or other prescribed medications, indicates an addiction.	Tolerance, withdrawal, and physiological dependence are expected responses to opioids and other controlled substances when given in sufficient doses over time, and are not, by themselves, indicative of addiction.
Addiction can accurately be predicted in patients, and diagnosed at intake.	Addiction is not an entirely predictable response to reward-producing drugs, but may occur in biologically and psychologically susceptible individuals, and is diagnosed over time, based on established criteria.
Anxiety and/or a lack of adherence to pain medication regimens indicate addiction.	Distress behaviors and psychiatric disorders often coexist with persistent pain, and do not necessarily indicate addictive behaviors.
Medications for pain or anxiety should not be used in patients with any history of a substance use disorder.	Uncontrolled pain, anxiety and other psychiatric illnesses may trigger a lapse or relapse to substance use, or exacerbate an existing disorder; treatment should be individualized, and may include alternative treatment modalities, monitored prescriptions, or other measures as needed.
Behaviors such as "clock-watching," preoccupation with obtaining medication, deception, stockpiling unused medication, and illicit substance use indicates addiction.	Patients with undertreated pain may engage in problematic behaviors that may appear abuse-like, which resolve once pain is adequately controlled ( <i>pseudoaddiction</i> , Fudin, Levasseur, Passik, Kirsh, & Coleman, 2003).
Substance misuse is the same as substance abuse, dependence, or addiction, and requires stopping all opioids.	There are many reasons for substance misuse, including varying cultural values, lack of education, misunderstandings, or poor judgment, which 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.

**Table 2****Ethical Principles with Clinical Practice Application**

<b>Ethical Principle</b>	<b>Application to Clinical Practice</b>
Autonomy and Dignity	Patients must be fully informed of treatment risks, benefits, and alternatives to preserve dignity and autonomy. This includes a complete discussion regarding the use of opioids when the patient has a known substance use disorder.
Beneficence	Requires that care be delivered in the patient's best interest. This includes appropriate screening for addiction risk. If the patient demonstrates an underlying substance use disorder with exposure to controlled substances, a clear plan of care is required.
Nonmaleficence (do no harm)	Requires monitoring for substance use and medication misuse in a stigma-free environment (Gourlay, et al., 2005; Heit & Lipman, 2009). Discharging a patient from care without appropriate transfer of care or referral to another provider may lead to patient harm and is deemed maleficent.
Justice	Every patient should have equal access to pain management and be treated with the same level of vigilance, dignity, and respect, regardless of a coexisting substance use disorder (Savage, Kirsh, & Passik, 2008).
Fidelity and Veracity	Ethical decisions (reasoned and systematic moral decision-making) and behaviors are bound by the moral obligations of veracity (truthfulness) and fidelity (faithfulness) (Beauchamp & Childress, 2009; Brown & Bennett, 2010).

**Table 3**

## Risk Stratification

<b>Low Risk</b>	No past/current history of a substance use disorder No family history of a substance use disorder No major untreated psychiatric disorder Presence of social support System	May be safely managed in primary care settings Adherence monitoring at least annually
<b>Moderate Risk</b>	History of treated substance use disorder Significant family history of substance use disorders Past or concurrent psychiatric disorder Current pharmacotherapy for addiction (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
<b>High Risk</b>	Active substance use disorder or aberrant behaviors Active addiction Majoruntreated psychiatric disorder	Recommended management by pain management and addiction specialists as needed, as these patients pose significant risk to themselves and others Frequent adherence monitoring weekly or monthly

Adapted from Gourlay, et al., 2005

**Table 4**

Pediatric Risk Assessment

<b>Pediatric Demographic Variables Related to Nonmedical Use of Opioids</b>	
Gender	Females (2 times more likely than males)
Age (lifetime prevalence, at least one use)	Use increases with age: 4.9% ages 12–13 8 % ages 14–15 16.4 % ages 16–17
Race	White, non-white Hispanic, mixed race, Native American/Alaskan
Education	School drop-outs, no plans for college
Health Indicators	Perceived poor to fair health, hospitalization in past year, 3+ ED visits in past year
<b>Characteristics <u>A</u>ssociated with Prescription Opioid Abuse and Dependence</b>	
Abuse	Poor to fair health, non-student
Dependence	Female, polypharmacy, illicit drug-dealing
<b>Characteristics <u>C</u>ommon to Prescription Opioid Abuse and Dependence</b>	
	Weekly nonmedical opioid use, history of major depressive episode, disordered alcohol use in past year

Adapted from Frese & Eiden, 2011