

Pain Management in the Chemically Addicted Patient

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Background

- Pain is the number one reason people seek health care in the U.S.
- Despite the prevalence of pain many people across the country receive inadequate pain management even with a terminal illness
 - Studies have indicated that as many as 40 % people with cancer do not receive adequate pain management (Cleeland et al. 1994)
 - Similarly up to 80 % of people with AIDS may be under-treated for their pain (Breitbart, 1996)

How Many Americans Have a Drug "Problem"?

- Nicotine 20%
- Marijuana 14%
- Alcohol 6-12%
- Opioids 3.5-7%
- Any illicit drug(s) 8%
- Prescription drugs 3.5%

Prevalence: 4% (MMA 85) of them are >100,000 OPCS, 1991-2010 drug 2007-2010 (MMA 85)



Pain Definitions

- Pain:
- “An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Pain is always subjective. Each individual learns the application of the word through experiences related to injury in early life...It is unquestionably a sensation in a part or parts of the body but it is always unpleasant and therefore and emotional experience (International Assoc. for the Study of Pain, 1979)

Pain Definitions

- Pain
- “Whatever the experiencing person says it is, existing whenever s/he says it does”
- (McCaffery, 1968)

Background

- Under-treatment of pain in the hospital is usually the result of one of three factors:
 - Patient under-reporting of pain
 - Physician under-prescribing of pain medication
 - Nurses under-administering pain medication

Important Definitions

- Physical Dependence-Adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug and /or administration of an antagonist (AAPM, APS, ASAM, 2001)

Important Definitions

- “Tolerance-Normal neurobiological event characterized by the need to increase the dose over time to obtain the original effect
- Cross Tolerance-Normal neurobiological event of tolerance to effects of medication within the same class” (Alford et al. 2006)

Important Definitions

- Addiction- A primary chronic, neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestations. IT is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving (AAPM, APS, ASAM, 2001)

Important Definitions

- Pseudoaddiction-An iatrogenic syndrome created by the under-treatment of pain. It is characterized by patient behaviors such as anger and escalating demands for more or different medications and results in suspicion and avoidance by staff. Pseudoaddiction can be distinguished from true addiction in that the behaviors resolve when pain is effectively treated (Weisman & Haddox, 1989)

Definitions

- Drug Seeking Behaviors-Directed behavior to obtain opioid medication or to ensure an adequate supply of medication; may be an appropriate response to inadequately treated pain
- Therapeutic Dependence- Drug seeking behavior due to the fear of re-imergence of pain and/or emergence of withdrawal symptoms

» (Alford et al., 2006)

Barriers to Adequate Pain Management

- Lack of accountability
- Lack of education of health care professionals
- Inadequate assessment of pain
- Fear of addiction
- Fear of respiratory distress
- Regulatory fears
- Patient and family fears

Additional Barriers

- People with a substance abuse problem face additional barriers to pain management
 - Health care professionals often have:
 - Inadequate knowledge about pain management
 - Inadequate knowledge about addictive disorders
 - Fears of being “conned” or contributing to addictive problems

Consequences of Pain

• Immobility	• Falls
• Deconditioning	• Malnutrition
• Sleep disorders	• Increased stress
• Immune dysfunction	• Depression
• Respiratory disorders	• Neurological changes
• Anxiety	• Mood disorders

Co-existing health concerns...

- Psychiatric co-morbidity
- Obesity/malnutrition
- Unstable neurological status
- Withdrawal states (Abstinence Syndromes)
- Effects of specific drug use on bodily health systems
- TB exposure
- Acute and Chronic Pain issues with co-existing Addictive Disorders
- Venereal Disease/unwanted pregnancy
- Sequelae of *occasional* or *consistent* drug use

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Psychiatric Co-morbidities

- Depression (30-54 % of chronic pain pts)
- Anxiety
- Delirium
- Sexual Dysfunction
- Sleep disorders
- Somatoform Disorders

Risks of Addiction

Studies indicated higher risk than previously thought

Risk of addiction in chronic pain population : 3.2- 18.9 % (Portenoy, 86; Katon, 85; Fishbain, 86; Steele-Rosomoff, 90; Evans, 81; Fishbain, 92)

Prevalence of Pain In Substance Abusing Patients

- Roland (1999) 650 Methadone treatment patients: 25 % needed acute medical care, 33 % needed chronic care and 55 % HIV care
- Jamison, Kaufman & Katz (2000) 248 Methadone patients: 61.3 % had chronic pain; when compared with those without pain they had more psychiatric problems as well as more use of prescription and nonprescription drugs
- 44 % of those with pain reported that pain meds did lead to difficulties with addiction

Pain Research

- Breitbart et al. (1997) looked at pain in AIDS patients with and without substance abuse problems and found:
 - No differences in reports of pain
 - Significant differences in psychological distress and adequacy of pain treatment
 - Higher levels of depression, distress, fewer social supports poorer quality of life and were significantly more likely to receive inadequate pain management

Research

- Kaplan et al (2000) compared morphine dosage and effectiveness in AIDS patients with and without substance abuse problems
 - Those with substance abuse problems required higher doses of morphine to manage their pain
- Martin & Ingles (1965) and Ho & Dole (1979) found that those with substance abuse problems had different pain thresholds and lower pain tolerance than those without a substance abuse problem

Additional Factors

- Relationship between traumatic injury and chronic pain and incidence of addiction
- Relationship between substance abuse and physical/sexual abuse in childhood and the development of chronic pain
 - 30-50 % of chronic pain patients have experienced physical, sexual abuse or abandonment as children
 - Also high occurrence of physical/sexual abuse in substance abusing families

Hyperalgesia

- Opioid-induced abnormal pain sensitivity has been observed in patients treated for both pain and addiction (Brodner, 78; Taylor, 80; Savage, 96; Compton, 94; Doverty, 01; Schall, 96; Dyer, 99)
- “A neuroplastic change in pain perception resulting in an increase in pain sensitivity to painful stimuli, thereby decreasing the analgesic effects of opioids” (Alford et al., 2006)

Basic Assessment of Pain

- Focus on patient description of pain
 - Where is the pain? (more than one site of pain)
 - Use of rating scale-pain intensity
 - What is the worst pain you have experienced?
 - How does that compare with present pain?
 - How often do you have this pain?

Pain Assessment

- How often do you have this pain?
 - When did it begin?
- Describe the pain (listen to description)
 - Somatic pain (muscles, joints, bones) is usually localized: Gnawing, annoying, throbbing, dull aching, constant, nagging
 - Neuropathic pain (nerve): burning tingling, prickling, electric, itching, shooting, stabbing
 - Visceral pain (poorly localized) variety of descriptors: bloating, cramping, gassy, sharp, boring, cutting

Pain Assessment

- When is the pain at its worst? The best (least)?
- What level of pain is acceptable to you?
- What have you tried that has made the pain better?
 - Relaxation, change of position, distraction, medication, heat, cold, other
- Does the pain keep you from your normal activities?
 - Effect on sleep, eating, bathing, dressing, going to work, leaving the house, recreation
 - Impact on relationships, capacity for intimacy

Pain Assessment

- Dose and frequency of all pain medications
- How long does the relief (from medication) last?
- Any side effects from the medications?
- Psychological component
 - Mood and affect-assess for suicidality
 - Cognitive function

Assessment Concerns

- Any factor that interferes with or diminishes the communication with patients poses a threat to the adequacy of the assessment and appropriate treatment of pain

Under-treated/underserved populations:

IV drug users, women (esp. African-American women), the very poor, very ill, very old and very young

Four Common Misconceptions of HCP resulting in under-treatment of pain in substance abusers

1. The Maintenance opioid agonist (Methadone or Buprenorphine) provides analgesia
2. Use of opioids for analgesia may result in addiction relapse
3. The additive effects of opioid analgesics and maintenance therapy may cause respiratory and CNS depression
4. Reporting pain may be a manipulation to obtain opioid medications, or drug-seeking, because of opioid addiction

» (Alford, et al., 2006)

Principles for Using Analgesics

- By the Step
- By the Clock vs. PRN
 - “Allowing pain to reemerge before administering the next dose causes unnecessary suffering and anxiety and increases tension between the patient and the treatment team”

» (Alford, et al., 2006)



- Adequately trial each drug
- If the gut works... use it!

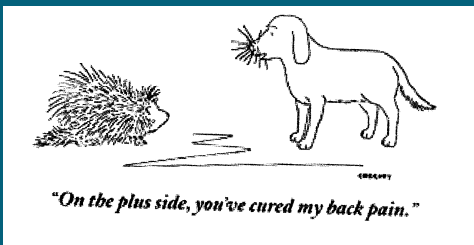
The Four "A's" of Pain Treatment Outcomes

- Analgesia (pain relief)
- Activities of Daily Living (psychosocial functioning)
- Adverse effects (side effects)
- Aberrant drug taking (addiction-related outcomes)

Non-pharmacological Methods

- Heat/Cold Application
- Relaxation techniques
- Massage
- Exercise
- Positioning
- T.E.N.S
- Acupuncture
- Distraction
- Imagery
- Music

Non Pharmacologic Pain Management



"On the plus side, you've cured my back pain."

Aberrant Drug-taking Behaviors: The Model

- Probably more predictive
 - Selling prescription drugs
 - Prescription forgery
 - Stealing or borrowing another drugs
 - Injecting oral formulations
 - Obtaining prescription drugs medical sources
 - Concurrent abuse of related drugs
 - Multiple unsanctioned dose escalations
 - Recurrent prescription losses (Passik & Portenoy, 1998)
- Probably less predictive
 - Aggressive complaining about need for higher doses
 - Drug hoarding during periods patient's of reduced symptoms
 - Requesting specific drugs
 - Acquisition of similar drugs from non-from other medical sources
 - Unsanctioned dose escalation illicit 1-2 times
 - Unapproved use of the drug to treat another symptom
 - Reporting psychic effects not intended by the clinician

Pain Patient's Bill of Rights

- “Too often a patient’s request for more or different medications is erroneously assumed to be addiction, and the possibility of under-treated pain is not explored”
– (ASPMN, 2003)
- Patients with addictive disease have the right to be treated with respect and to receive the same quality of pain management as all other patients. Providing this care addresses the potential for increased drug use or relapse associated with unrelieved pain (ASPMN, 2002)

Some things work for

Some people

Some of the time!



Recommendations

- Pain Management for all Patients with addictive disease:
 - Team of providers to assess both pain and addiction
 - Enhance support systems
 - Involve patient in planning, use nonjudgemental approach
 - Provide verbal and written explanations and information – *contracts and contingency plans**
 - Educate

Recommendations (cont.)

- CONSISTENCY
- ATC medication vs. PRN
- PCA
- Opioid cross tolerance and increased sensitivity to pain may require higher doses and more frequent intervals
- Avoid mixed agonists and antagonist opioids because they may precipitate a withdrawal syndrome

Recommendations (Cont.)

- Adjuvant medications
- Non-pharmacological treatments
- Open discussion about misuse of medications
- Use of urine toxicology screens and contracts
- Assess for other psychological problems and treat
- Taper of medication when no longer needed

Recommendations for patients who are actively using drugs

- Distinguish between pseudoaddiction and addiction
- Assess and treat for symptoms of withdrawal from other substances
- Openly discuss use of other drugs if patient acknowledges such use
- Assess for psychiatric co-morbidity and treat if present
- Once pain is controlled educate about addiction and services available

Recommendations for patients in recovery

- Explain and discuss any plan to use psychoactive substances as part of treatment
- Explain risks (health and quality of life) of unrelieved pain, including risk of relapse
- Involve family, S/O, supports in conversation where appropriate and patient gives permission
- Respect the patients' wishes

Recommendations for patients in recovery

- Encourage active participation in recovery programs
- If relapse occurs, intensify recovery efforts, do not terminate pain care

Recommendations for patients on Methadone Maintenance

Contact Methadone treatment team to discuss pain management issues

- Methadone doses should continue for treatment of opioid addiction but are not to be relied upon for analgesia (pain management)
- For analgesia:
 - Add another opioid on an ATC basis
 - Give additional Methadone doses. Methadone for analgesia requires more frequent dosing (i.e. every four to eight hours)

Recommendation for Patients on Buprenorphine Maintenance

- Continue buprenorphine maintenance and titrate short-acting medications for short duration only
- Divide buprenorphine doses to every 6-8 hours
- Discontinue buprenorphine maintenance and use opioid analgesics (convert back when acute pain has subsided)
- If hospitalized, switch from buprenorphine to treat opioid dependence with methadone and use short-acting opioid to treat pain. Have naloxone at bedside. Discontinue methadone and convert back to buprenorphine before discharge. (Alford et al., 2006, p. 130)

Part II

- *Staff attitudes
- *Ethical concerns
- *Strategies and tools to assist & promote compliance

Relapse...

- Occurs with all chronic diseases
- Examine the *Stage of Change*
- Self-perception of Health
- Why does it occur?
- What went well...what didn't ?
- Chronic diseases have exacerbations and remission of symptoms

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Why are individuals with an addictive disorder under-treated for their pain?

Attitudes...

When the only tool you have in your box is a hammer... then everything begins to look like a nail!

How do we define pain?

“Whatever the experiencing person says it is, existing whenever s/he says it does”

McCaffery, 1968

Really?

What if what is ordered is never enough and the complaints of pain are constant?

Or you believe medicating the pain has precipitated a relapse to the person's DOC?

Then what?

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Staff Issues

- Maintain perspective
- Utilize other team members expertise- psychiatric, pain and addictions specialists
- Develop your own supports in dealing with this difficult issue

Patient example #1

- 32-year-old, divorced, homeless female with criminal record.
- Multi-cultural background. 1 child removed from the home by DSS.
- No current insurance. Mother died of AIDS and brother now incarcerated. Siblings all use various substances.
- Medical history: HIV+, HCV+, r/o TB, and asthma. Sustained multiple FX - domestic altercations with boyfriend. Now being treated for Candida osteomyelitis of the spine. C/o of severe pain unrelieved by current medication and dosages.
- Substance abuse: long HX of alcohol and opiate dependence with cocaine use. Refuses to attend NA/AA. No interest in pharmacological intervention for chemical dependence.
- Admitted to acute hospital with shortness of breath, respiratory failure and aspiration pneumonia. Underwent tracheotomy.
- Followed by Psychiatry: Suffers from PTSD...raped 8 years ago. Suffered physical and sexual abuse by biological parents as a child. Non-compliant with treatment plan for psychopharmacology. Has considered suicide in the past - no current SI or plan. Assessed as competent.
- Hospitalized for 6 weeks.

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Patient example #2

- 56-year-old male, Spanish-speaking, wheelchair-bound.
- Medicaid insurance.
- Admitted from YMCA for diagnosis of mental status changes and hyponatremia (low sodium).
- Status/post motor vehicle accident with sub-dural hematoma, and back and hip fractures sustained while drinking. (Riding on R side of car w/o seat belt). C/o constant pain unrelieved by current medication and dosage. Seen by Nursing staff as chronically "med-seeking".
- Medical history includes hypertension, agitation, hyperlipidemia, and type 2 diabetes (diet controlled.) Placed on strict fluid restriction.
- Substance abuse: alcohol and cocaine, and sporadic use of opioids. Has had several SA treatments but is rejected by many due to ongoing medical and health needs. *States boredom and lack of socialization are triggers for him to relapse.*
- No family supports. Does not attend any self-help or recovery groups. Attended a Spanish group but was erratic in attendance due to transportation issues.
- After lengthy acute hospital stay, eventually discharged to SNF on several medications with plan for return to YMCA where he had been residing.

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What tools do you have?



Medication Agreement

- Explain that the agreement is to protect:
 - Their access to opioid therapy
 - Their abstinence and recovery
 - Your prescribing authority*
- Compliance expectations
- Authorization for information sharing
- Consequences of noncompliance
- Goal of improved quality of life



Fishman SM, et al. *J Pain Symptom Manage.* 1995;10:27-37.

Urine drug screening



- Use as deterrent, not to 'catch in the act'
- Random and witnessed*
- Standardized urine collection by nurses
- Patient can build 'good credit'
- Verify prescribed meds
- Look for unauthorized substances

Courtesy of Dr. Michael Weaver, Virginia Commonwealth University

Dealing with results

- Have a plan for dealing with results of urine drug screens
- Decide what is serious and less so
- Give patient the benefit of the doubt for a disputed result
- Watch for a pattern



Courtesy of Dr. Michael Weaver, Virginia Commonwealth University

Why is understanding hyperalgesia so important when working with this population?

Humane Clinical approaches...

- Be respectful
- Be flexible...not everyone in the world will think or agree with you
- Unconditional regard
- Be engaging rather than confrontational
- Be alert for personal control issues
- Communicate acceptance of the patient and treat the *disease...*

Critical Components to Healthcare Delivery Systems...

- Non-judgmental approach
- Assertive outreach
- Motivational interviewing
- Knowledge of the *Stages of Change*
- Staged Intervention

-Johnson Institute

Remember...

*Good pain management is
good relapse prevention!*

Ethical Mandates...

- You are duty bound to treat pain and suffering in a human being.
- Mandates of beneficence and justice require our humanity *to all whom we care for.*

In closing...

*"...must be prepared to advocate for appropriate and
adequate management of pain experienced by all
persons, including those who are chemically addicted".*

Quinlan-Colwell 2002

Treat Addiction Save Lives

Resources...

- Hazelden Foundation-Publishing
- ASPMN -Position Statement in Patients with Addictive Disease 1-888-342-7766
- Morgan, Betty (2005) "Knowing How to Play the Game" (copy provided)
- American Society of Addiction Medicine www.asam.org
- www.PainEDU.org
- www.masspaininitiative.org

Resources

- Drug Dependence, a Chronic Medical Illness
McLellan, Lewis, O'Brien, Kleber JAMA 2000;284(13)
- Improving Clinical Performance in Hospitals, Ettinger, W. (2008)
Prescriptions for Excellence in Health Care
- Lacy, C., Armstrong, L., Goldman, M., & Lance, L. (2000). *Lexi-comp's clinical reference library: drug information handbook*. Hudson, OH: Lexi-Comp Inc.
- Long, Phillip W. M.D., (2004). retrieved Dec. 05, 2004, from Internet Mental Health Web site: www.mentalhealth.com.
- Stern, T., Herman, J., & Slavin, P. (2004). *Massachusetts general hospital: guide to primary care psychiatry*. 2nd ed. New York: McGraw-Hill.
- U.S. National Library of Medicine, (2004). Trusted health information for you. retrieved Dec. 05, 2004, from Medline Plus Web site: <http://www.nlm.nih.gov/medlineplus>.
