Patients with Chronic Pain & Substance Abuse

A NEED-based approach

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Conflict of Interest Disclosure
Paul Arnstein 2012 - 2014

• Sterling Labs: Scientific Advisory Panel
• Zogenix: Scientific Advisory Panel
• Janssen: Scientific Advisory Panel
• Mallinckrodt: Scientific/Nursing Advisory Panel
• Gannet publications: Author & editor
• F.A. Davis Publishers: Author
• Nurse Practitioner Healthcare Foundation: Speaker, Author
• American Pain Society: Speaker (FDA-REMS content)
Pain affects the whole person

- Severe or persistent pain sends ripples through the nervous system, invading the person’s whole life... personality... and relationship with the world ...
The Problem of Chronic Pain

- Affects 15-50% of adults (>100 Million Americans)
  - May be resultant from incurable disorders
  - May be an incurable nervous system disorder
  - May be a curable condition not properly treated
    - 20-50% post-op / post trauma patients have pain at 1 year
- Accounts for 40 million outpatient visits
- # 2 reason for hospitalization
- Medical expenses, > $100 Billion/yr in CMS $
- Lost income and reduced productivity
- >$600 Billion/yr in disability & replacement costs
Undesirable Effects of Chronic Pain

• Leading burden of illness & disability worldwide
  – More than cancer, heart disease, diabetes & stroke combined

• Health care expenditures $10,000/pt. year

• 5–10% loss of gray matter (~= 20 years aging)
  – Slows/reverses with pain control

• 30-50% higher all-cause mortality in 10 years

• Chronic exposure to potential dangerous drugs

IOM 2011. Relieving Pain in America…Washington DC:

Potential Harm from Pain Medications

• Leading cause of drug-related hospitalization
  – 25% involving older adults related NSAID toxicity
  – >1 million opioid (70% Medicare, 30% Medicaid) hospitalizations

• 1 million older adults/yr go to ED for ADEs
  – 9% involve opioids and 8% nonopioid analgesics

• Opioids leading cause of overdose deaths
  – 77% Benzodiazepine deaths – also had opioids
  – 65% antiepileptic/anti-parkinson deaths w/ opioid

Samhsa.gov/data/2k10/TDR013AdverseReactionsOlderAdults/AdverseReactionsOlderAdults.HTML.pdf
Young (2014) CQ Healthbeat. Medicare Sees Most Growth in Opioid-Related Hospitalizations
Opioid Deaths Are the "Tip of the Iceberg"

Adapted from: CDC NCIPC November 2011 updated with AHRQ 2014 report (16,917 deaths; ~700,000 ER visits)

People living with Pain: Chronic >116,000,000; Acute >50,000,000

In 2008, there were 14,800 prescription painkiller deaths.⁴

For every 1 death there are...

- 10 treatment admissions for abuse⁵
- 32 emergency dept visits for misuse or abuse⁶
- 130 people who abuse or are dependent⁷
- 825 nonmedical users⁷

Plus 608 People Prescribed Chronic Opioid Therapy

People living with Chronic Pain: 6,757

Adapted from: CDC NCIPC November 2011 updated with AHRQ 2014 report (16,917 deaths; ~700,000 ER visits)
Opioid Pain Relievers

Block pain signal transmission and alter perception of pain
Opioid Analgesia

**NEURON IN THE ABSENCE OF AN OPIOID**

At a normal resting potential, the neuron is primed to fire an action potential.

**NEURON IN THE PRESENCE OF AN OPIOID**

1. Opioid receptor
2. Ca\(^{2+}\) channel closed
3. K\(^{+}\) channel open

The hyperpolarized neuron is less likely to fire an action potential.

Ca\(^{2+}\) channel open

K\(^{+}\) channel open

cAMP levels decrease

Opioid receptor

Opioid
Nerve terminals in nucleus accumbens

1. GABA receptor
2. Mu (μ) opioid receptor
3. Dopamine receptor

GABA

Morphine

Post-synaptic membrane

Dopamine
Opiates & Reward Centers
Areas of CNS Affected by Pain

- PB: Parabrachial Nucleus
- PAG: Periaqueductal Gray
- AMYG: Amygdala
- HYP: Hypothalamus
- PO: Posterior Complex
- MDvc: Medial Dorsal Nucleus: ventral caudal part
- VPL: Ventroposterior Lateral Nucleus
- PFC: Prefrontal Cortex
- ACC: Anterior Cingulate Cortex
- PCC: Posterior Cingulate Cortex
- PPC: Posterior Parietal Cortex
- SMA: Supplemental Motor Area
Physiological areas associated with mood, emotion; & psych/mental illness

Imbalance in noradrenaline, serotonin & Gamma-aminobutyric acid (GABA)
Neurophysiology of Addiction

• Importance of Serotonin & Dopamine pathways
  – Effects of drugs (incl. alcohol) on these transmitters
Expected opioid effects

• Analgesia

• Side effects

• Tolerance
  – Diminution of one or more opioid effects

• Physical dependence
  – Abstinence syndrome
Undesirable Opioid Effects

– Respiratory depression, bronchospasm
– Sedation, dizziness, ataxia, visual disturbances
– Nausea / vomiting, constipation
– Urinary retention, sexual dysfunction
– Itching, skin rash
– Immune, hormonal or neurological problems
– Psychosocial problems
– Behavioral / existential problems
AHRQ (2014) report on chronic opioid therapy efficacy & risks

• 39 of 4,209 studies met quality standards
  – Differences in definitions & measures preclude the ability to deduce comparative effectiveness & risks
  – Strength of evidence was rated no higher than low

• Lack evidence to know benefits & harms

• Most patients do not develop drug problems
  – opioid abuse 0.6% to 8%
  – Rates of dependence were 3.1 % to 26%
  – aberrant drug-related behaviors 5.7% to 37.1%

Opioid withdrawal signs

• Begin hours or days after last dose
  – Timing & severity may relate to dose/duration of use
  – Established by five elimination ½ lives of drug

• Symptoms include multiple systems
  – Psychological: Anxiety; craving, fixated on getting drug
  – CNS: Tremors, restless, pain, myoclonus, insomnia, hypertonia, crying, dilated pupils, possible seizures
  – Autonomic: Fever, sneeze, rhinorrhea, sweating, yawn, gooseflesh, tachycardia, hypertension, tachypnea,
  – GI: Diarrhea, nausea, vomiting, anorexia, pain/cramps
Inability to consistently **Abstain**

Impairment in **Behavioral** control

**Craving** or increased hunger for drugs or rewarding experiences

**Diminished** recognition of significant problems with one’s behaviors & interpersonal relationships

A dysfunctional **Emotional** response
# Differential Diagnosis

Opioid Induced Hyperalgesia (OIH) or something else?

<table>
<thead>
<tr>
<th></th>
<th>Tolerance</th>
<th>Withdrawal</th>
<th>OIH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased dose helps</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pain sensitivity</td>
<td>Same</td>
<td>Increased</td>
<td>Increased</td>
</tr>
<tr>
<td>Pain distribution</td>
<td>Same</td>
<td>Same or Increased</td>
<td>Increased</td>
</tr>
<tr>
<td>Opioid doses</td>
<td>Same</td>
<td>Reduced</td>
<td>Increased or same</td>
</tr>
</tbody>
</table>
Opioids: Balancing Risks and Benefits

- Opioid Analgesia
  - Reduced Pain
  - Improved QOL
  - Improved function

- Opioid Adverse Effects
  - Side-effects
  - Drug-interactions
  - Accidental ODs
  - Risk of OIH
When opioids are / not indicated

• Indicated
  – Moderate-severe acute pain (¿15-30 days)
  – Cancer pain / severe pain at end of life
  – Chronic non-cancer pain benefits>risks (controversial)

• Contraindicated
  – True allergy
  – Untreated addiction disorder
  – Unmonitored environment (rescue equipment)
  – Drug diversion confirmed
Avoiding Overdose

• Patient selection based on risk

• Lower risk by drug selection (highest to lowest risk /Rx)
  – Methadone, morphine, hydrocodone, fentanyl, hydromorphone, oxycodone, buprenorphine
  – Tramadol and Tapentadol

• General & tailored dosing
  – Most overdose deaths include >1 drug
  – Rx poisonings 8% non-opioids; 9% opioids

1. CDC (2012) MMWR July 12 61(26);493-497
Opioid right for Monte Torre?

80 y/o w/ chronic disabling OA pain

Non-opioid therapies ineffective, IR opioids provided some relief but too many pills with end-of-dose failure and poor sleep

– Sometimes forgets if he took medication
– No psychiatric/drug abuse Hx or comorbidity
  • Potential benefits appear to outweigh potential risk
  • Vigilant monitoring, regardless of patient

Universal precautions when prescribing long-term opioids

• Make a diagnosis with appropriate differential
• Psychological assessment (including risk of addiction)
• Informed consent & treatment agreement
• Pre-treatment assessment of pain level & function
• Trial of opioid therapy with adjunctive therapy
• Reassessment of pain score and level of function
• Regularly assess the four A’s of pain medicine
• Periodically review pain diagnosis & comorbidity
• Documentation
Acetaminophen

• Safe, well tolerated analgesic & antipyretic
• Weak peripheral anti-inflammatory action (acts centrally)
• 1\textsuperscript{st} line non-opioid choice for children & elders
• Growing concerns about hepatic toxicity
  – Avoid with liver failure; alcoholism
  – Multiplicity of doses / inadvertent exposures
  – Concerns with drug interactions (warfarin, hepatotoxic)
  – A co-ingredient in many opioids (unauthorized dose escalation)
Safe NSAID Use: Short-Term

• NSAID selected based risk profile
  – Ibuprofen with no (GI, heart, renal) risks
  – Naproxen may be safest with cardiac risks
  – Nonacetylated salicylates or COX-2 with GI Risks

• No Aspirin given to children

• Avoid NSAIDs with cardio protective aspirin
  – Often interferes with cardio protective effect
  – Increases risk of GI bleed

• Administer NSAIDs @ lowest dose; shortest time
  – With food and a full glass of water
  – Maintain adequate hydration

Scheiman JM, et al. (2005)
AGS Guidelines, 2009
Risk Factors for NSAID-Associated GI Complications

- Past Complicated Ulcer: 13.5
- Multiple NSAIDs: 9.0
- High-Dose NSAIDs: 7.0
- Anticoagulant: 6.4
- Past Uncomplicated Ulcer: 6.1
- Age >70 Years: 5.6
- SSRIs: 3.6
- Steroids: 2.2

SSRI = selective serotonin reuptake inhibitor.
Monte Needs: Safe, Effective Pain Treatment

- Therapeutic communication/use of self, prayer, rituals, CAM, pet therapy, support groups
- Coping strategies, relaxation/imagery; patient/family education & counseling music, distraction, cut fear, anxiety, sad
- Reduce extraneous stimuli; stimulation (proximal, distal, contra-lateral), positional alignment, physical manipulation, SCS
- Heat, cold, position, orthotics, exercise, massage, wound support, TENS, compression, rehabilitation
Is Monte Opioid tolerant or naïve?

• Growing number of opioid tolerant patients
  – Lower threshold and less tolerant of pain
    • May be more tolerant of opioid side effects
  – May develop opioid-induced hyperalgesia
    • Paradoxical increase in pain with increasing doses
  – May develop withdrawal syndrome with
    • Abrupt lowering / stopping therapy or antagonist use

• Opioid naive at greater risk of overdose
  – Pill burden & confusion also a risk in this case
General Rule with Older Adults

• Start Low
  – 25 – 50% lower than young adults
  – Exception in opioid exposed or tolerant
    • Go by prior responses and established needs
• Go Slow
  – Longer duration of action
    • Longer to reach pharmacological steady state
    • Titrate slower
• But Go!
The case of Demi Moore (new admit)

41-year-old, mother (of 3) w/ severe LBP

- Emotional and financial stress
- MRI: Marked degeneration L\(_{4-5}\) \& L\(_{5-S1}\)
- Deemed not a surgical candidate
- Other medical Hx non-contributory
- Demanding opioids ASAP
Rx History

• Failed trials NSAIDs, APAP & adjuvants

• $10_{\text{mg}}$ oxycodone QID started 4 months ago
  – Partial, temporary relief: improved role functioning
  – Aberrant behavior
    • Early refill requests, a lost prescription
    • Angry demands past 2 months for more drugs
    • History of Marijuana and Cocaine use in her 20s

• Opioids are not a Rx of choice with non-cancer pain
  – Requires intensive structure, monitoring, & management by clinician w/ expertise in both addiction & pain
    • Undertake only if risks can be adequately managed
Identify risk of developing aberrant behaviors not initially present

Opioid Risk Tool

• Age 16-45 (1pt)
• Personal Hx SA: Alcohol (3pt), illicit (4pt), prescription (5pt)
• Family History of SA (1 – 10 pts depending on above specifics / gender)
• Hx: Depression (1pt), ADD, OCD, bipolar, schizophrenia (2pt)
• Hx of pre-adolescent sexual abuse (F 3pt)

0-3 low risk: 6% chance of developing problematic behaviors
4-7 moderate risk: 28% chance of developing problematic behaviors
>= 8 high risk: >90% chance of developing problematic behaviors

Demi Moore score = 5 based on age & personal/family substance use history
Aberrant Drug Behaviors

Hx positive for some less predictive* signs

• Aggressive complaining for more drugs
• Drug hoarding
• Requesting specific drugs
• Acquiring similar drugs from other MDs
• Unsanctioned dose escalation >1 time
• Use of drug to treat another symptom
• Resistance/anxiety to change therapy

Aberrant Drug Behaviors

Hx may include a “more predictive” sign*

- Multiple episodes of prescription loss
- Seeking Rx from other prescribers without informing primary prescriber after warning
- Deteriorated functioning (physical, mental, social)
- Resistance to change therapy despite clear physical / psychosocial problems

Aberrant Drug Behaviors
No Hx of the Most Predictive*

• Selling prescription drugs or Rx forgery
• Stealing or "borrowing" drugs
• Injecting oral formulations
• Obtaining drugs from nonmedical sources
• Concurrent abuse of alcohol or illicit drugs
• Multiple dose escalations after warnings

Pain control in patients at moderate addiction risk; or in relapse

• Treat pain with Specialty Support
  – Pain Service/Addiction Services

• Use multimodal therapy with analgesics
  – Not w/Benzos, phenothiazines, antihistamines

• Monitor for withdrawal: avoid antagonists

• Assess stressors for relapse
  – Talk openly re: stability/commitment of recovery
  – Drug of choice

• Understand pattern of use
  – Validate with drug tests & reports of significant others
Prescription Opioid Users Are Heterogeneous

Nonmedical Users
- Recreational abusers
- Patients with disease of addiction

Pain Patients
- Pain patients seeking more pain relief
- Pain patients escaping emotional pain

SUD = substance use disorder

Is Demi Drug-Seeking?

• Wants more drug despite:
  – Increased dose
  – Decreases quality of life & functioning
  – More side effects
  – Abandoning other aspects of Rx plan
• Drug seeking behavior escalates
  – Lost Rx, early refill, unauthorized dose change
• Excessive craving / focus
• Neglects responsibilities ... to get drugs
Is Demi Relief-Seeking?

• Titrating pain-relieving medication
  – Improves functioning
  – Improves quality of life
  – Helps focus on disease, rehab, Rx plan
• Drug seeking behavior subsides
• ~Express concern re: expected effects
  – Side effects, tolerance, dependence
Impact of pain on families

- Disrupts family functioning
- Protect children from exposure to opioids
- Family support needed to follow treatment plan
- Emotional trauma may occur
  - Strong feelings e.g. guilt, anger, sadness
  - Family members suffer witnessing pain in loved one
- Family distress can worsen patient’s pain
- Chronic stress & maladaptive responses within family may contribute to illness behaviors
Demi Needs: Diagnosis & Supervision

- Longitudinal trusting relationship w/ 1 prescriber
- Education & counseling
  - Protecting the prescription
  - Safe medication storage
  - Safe use
    - Travel precautions
    - Universal Precautions
    - Part of multimodal therapy
  - Safe disposal
- Exit strategy

Examples of Metabolism of Opioids

- Codeine → Morphine → 6-MAM$^*$ → Heroin
  - $t_{ss} = 25-30$ min
  - $t_{ss} = 3-5$ min
- Hydrocodone → Hydromorphone
- Oxycodone → Oxymorphone

Not comprehensive pathways, but may explain presence of apparently unprescribed drugs
Examples of Metabolism of Opioids

Codeine → Morphine → 6-MAM* → Heroin

Hydrocodone → Morphine → Hydromorphone

Oxycodone → Oxymorphone

\[ t_{1/2} = 25-30 \text{ min} \]

\[ t_{1/2} = 3-5 \text{ min} \]

*Not comprehensive pathways, but may explain presence of apparently unprescribed drugs

*6-MAM=6-monoacetylmorphine

32 y/o Irene Lee Nedoficks

- Admitted with cellulitis and sepsis
- Pain assessment
  - Nature – Burn, cellulitis, “Throbbing, sharp, aching”
  - Intensity “8”
  - Location Hand (cellulitis) other lesions; chronic shoulders
- Source of Pain Known / Treated
- Drug Abuse history + Heroin, +/-methadone
  - $2_{Gm} - 5_{Gm}$ Heroin = $\sim 24,000_{mg} - 48,000_{mg}$ oral morphine
- Nondrug Rx used in past
  - Extremely limited coping & “access” resources
  - Very limited motivation; & values in conflict
Hospitalized Treatment Regimen

- **9/22/14**  (840mg OME*) [Day of osteotomy surgery)
  - IV – Dilaudid 6mg x 7
- **9/23/14**  (780mg OME – 10% less than previous day)
  - IV Dilaudid 6mg x 6
  - Oral Morphine 30mg x1
  - Oral Morphine 15mg x2
- **9/24/14**  (285mg OME 63% less than previous day)
  - Oral Morphine 30mg x5 = 150mg
  - Oral Morphine 45mg x3 = 135mg

*OME = ORAL MORPHINE EQUIVALENTS: for opioids using the following calculation
1.5mg IV Hydromorphone = 30mg OME
Approximate pre-operative need:

Convert 42mg IV Dilaudid to oral morphine

**Method #1**: Calculate based on 0.05:1 potency ratio 30mg = 1.5mg

**Method #2**: Calculate based on cross-multiplication formula

\[
\frac{\text{Equianalgesic Table dose of current drug}}{\text{Equianalgesic Table dose of new drug}} = \frac{24\degree \text{ dose current drug}}{N} = \frac{(24\degree \text{ dose new drug})}{N}
\]

\[
\frac{1.5\text{mg IV Dilaudid}}{30\text{mg oral morphine}} = \frac{42\text{mg IV Dilaudid/day}}{N}\]

\[
30 \times 42 = 1.5 \times N = \frac{30 \times 42}{1.5} = N = 840\text{mg oral morphine/day}
\]
Day to day changes

Pre-admit 24,000 OME

96% cut

10% cut

63% cut

5% cut

55% more

OME
Opioid Withdrawal Severity

Severity of Withdrawal

Days Since Last Opiate Dose

0
5
10
15

Heroin
Buprenorphine
Methadone
“As of 2pm on 9/24 Ms. Nedoficks had 150mg Oral Morphine and is having moderate-severe symptoms of withdrawal. She is agitated, sweating with cold skin. On her current regimen (30mg po morphine Q3H prn) the most she could get in 24 hours is 240mg, a 70% reduction in dose from yesterday”
## Pain Treatment Plan

### Current regimen

<table>
<thead>
<tr>
<th>Current regimen</th>
<th>(check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗ Opioid</td>
<td></td>
</tr>
<tr>
<td>✗ Non-opioid</td>
<td></td>
</tr>
<tr>
<td>✗ Adjuvant</td>
<td></td>
</tr>
</tbody>
</table>

### 24 hour Oral MS Equivalents to prevent withdrawal and treat pain: Unknown.

~500mg OME 5-day average

Oral morphine
APAP
Ibuprofen
Gabapentin

Other Ideas?
# Methadone Dosing

Relative potency varies based on MS equiv

<table>
<thead>
<tr>
<th>MS equivalent (oral)</th>
<th>Ratio methadone - MS</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;90 mg/day</td>
<td>1 methadone : 4 morphine</td>
</tr>
<tr>
<td>90 -300 mg/day</td>
<td>1 methadone : 8 morphine</td>
</tr>
<tr>
<td>301-600 mg/day</td>
<td>1 methadone : 10 morphine</td>
</tr>
<tr>
<td>601-800 mg/day</td>
<td>1 methadone : 12 morphine</td>
</tr>
<tr>
<td>801-1000 mg/day</td>
<td>1 methadone : 15 morphine</td>
</tr>
<tr>
<td>&gt;1000 mg/day</td>
<td>1 methadone : 20 morphine</td>
</tr>
</tbody>
</table>

500mg oral MS = ~ 50mg Methadone ... but ...

Pain Management in Patients with Substance Use Disorders

I. Use Recommendations for All Patients
II. Maximize appropriate non-opioids, nondrug & interventions
III. Don’t substitute benzodiazepines, phenothiazines, antihistamines for analgesics
IV. Don’t use partial agonist or agonist-antagonist
V. When opioids not needed for pain, taper them slowly
VI. For patients in recovery from a substance use disorder
   a. Assess length & stability of recovery
   b. Expand treatment team to include addiction expertise
   c. Identify patient-specific stressors for relapse (e.g. unrelieved pain)
   d. Encourage open communication with patient & significant others

*International Nursing Society on Addiction (IntNSA) and American Society for Pain Management Nursing (ASPMN)
http://www.aspmn.org/Organization/documents/PainManagementinthePatientwithSubstanceUseDisorders_JPN.pdf
Pain Management in Patients with Substance Use Disorders (continued)

6. Vigilant monitoring, including controlled dispensing
7. Solicit family/significant other assistance
8. Consider less abusable formulations
9. Consider inpatient treatment for addiction as indicated
Abuse-Deterrent Formulations

- **Physical/Chemical barriers**
  - Prevent physical manipulation (e.g. chew, crush, cut, grate or grind)
  - Chemical barriers resist extraction of opioid (e.g. water, alcohol, solvents)
  - Physical & chemical barriers combined cut abuse potential.

- **Agonist / Antagonist combinations**
  - Reduce, or defeat the euphoria associated with abuse

- **Aversion**
  - Produces an unpleasant effect if not taken as directed

- **Delivery System**
  - (e.g. depot injectable formulations and implants)

- **Prodrug**
  - Only effective if passes through GI tract

- **Combination:** Two or more of the above methods can be
Abuse-deterrent Formula Options

– OxyContin reformulation mid-August 2010
  • Street demand evaporated within a year
– Opana Crush resistant Oxymorphone (IR & ER) approved Dec 2011
– Acurox, (Oxycodone + niacin) denied FDA approval
  • Niacin very unpleasant, required change
  • Oxecta (Reformulated Acurox without niacin) approved June 2011
    – Now crushes to chunks not powder if crushed & turns "sudsy" if mixed with liquid & drawn into a syringe
    – Physical & chemical tamper resistance
– Targiniq ER, (oxycodone + imbedded Naloxone) approved July 2014
– Xartemis™ XR (oxycodone HCl + acetaminophen + PolyOx) approved March 2014
  • Crushing, snorting, dissolving, injecting more difficult
– ...
When Tapering Doses

• Clarify reasons for tapering
• Subtraction therapy (taper 1 drug @ time)
• Method of tapering (individualize)
  – Fast track
    • Ultra-rapid/Inpatient detoxification programs
    • Cut by 20%-50%/dose/day then cut interval\(^1\)
  – Slow track (~ slower based on situation)
    • Cut dose by 10% each day or 25% each week\(^2\)
    • VA clinical Practice Guideline: LA drugs\(^1\)
• Higher dose, longer duration requires more time
  • Can take 5 days to 5 months depending on dose/duration
• Give physical & mental support through process

\(^1\)VA Practice Guideline (2003).  \(^2\)Katrina Disaster Working Group (AAPM, 2005).
Using Opioids in SUD Patients

• Never the only treatment
• Expanded treatment team needed (where available)
• Dosed to prevent severe abstinence syndrome
• Part of multimodal therapy
  – Drugs with different actions, Side-effect burden/toxicity
  – Consider individual vulnerabilities
  – Nondrug therapies
    • Detox, initiate and maintain the recovery process
    • Improve functioning, coping and self efficacy
WHENEVER A S.U.D. IS SUSPECTED

Screen for both pain / addiction ... treat &/or refer

- Group I: “My patient”
- Group II: “Specialty patient”
- Group III: “My patient with specialist support needed”

In a patient with pain and addictive disorder, it is important to treat both conditions.

Doing nothing for either pain &/or addiction represents substandard care.
When Patients have Addiction and Pain
Judge the Treatment, Not the Patient!

**DETERMINE ...**
- Do the benefits outweigh the risks to the patient & society?
- Is functioning affected?
  - Better or worse?
    - Physical
    - Mental
    - Social

**NOT ...**
- Is Patient good /bad?
- Does the patient deserve meds?
- Should the patient be punished or rewarded?
Irene NEEDS: Clear treatment goals

• Develop & maintain therapeutic relationship
  – Based on mutual honesty and respect
  – Avoid “lost to follow-up” or “discharged”

• Gain control of pain and drug use

• Harm reduction strategies in place

• Help patients think, feel, and do better!
Motivational Strategies

• Motivational Interviews
  – Express Empathy
  – Develop Discrepancy
  – Roll with Resistance
  – Support developing Self-efficacy

• Motivational Incentives
  – Reduces pain-related avoidance behavior
  – Improves addiction treatment adherence
  – Counselors not fond of monetary rewards

Getting Foundation of Motivators

• **Open ended questions re: drug/ nondrug Rx**
  – Good things about opioid use?
  – Down side of opioids?

• **Affirmation of strengths**

• **Reflection of core values**
  – ..what would you be doing a year from now?

• **Summary**

Tailor focus to Stage of Change
PRECONTEMPLATION

• Denies (or be unaware) of need to change
• Reluctant to discuss problem
• Others identify the problem
• Reacts when pressured or pursued
• Increased risk for argument
Strategies for Precontemplation

- Establish rapport / basic trust
- Ask permission to get more information
- Raise doubts/concerns about opioid use
  - e.g. Physical, psychosocial, legal
- Goals:
  - Consciousness raising
  - Lowering emotional arousal
CONTEMPLATION
(best time for Motivational Interview)

• Demonstrates willingness to discuss, read about, and consider the problem
• Considers pros and cons
• Still has ambivalence and attempts action
• Can be obsessive about the problem
• Obsessiveness may prolong this stage
Contemplation Stage Strategies

• Normalize ambivalence
• Help patient “tip” decisional balance
• SMART GOALS:
  – **S** pecific (Significant, Simple)
  – **M** easurable (Motivational, Manageable)
  – **A** ttainable (Achievable, Actionable)
  – **R** ealistic (Relevant, Results oriented)
  – **T** imely (Trackable, Time-specific)
DETERMINATION (Preparation)

• Admits & understands that change is necessary

• Initiates commitment to specifics
  – Goals, strategies and target dates

• Begins to picture overcoming obstacles

• May procrastinate about actual start date
STRATEGIES FOR PREPARATION STAGE

• Clarify goals & strategies
• Variety of options for treatment / change
• I.D. & plan to face barriers to change
• What has worked in the past
• Assist with issues / barriers:
  – Finances, transportation, child care, work
  – Other potential barriers
ACTION STAGE

• Behavior change as planned
• Tracks the behavior being changed
• Commits to identify / overcome obstacles
• Vulnerable to abandon plan with impulsive actions
  – Insight is valuable for future work / change
Strategies for Action Stage

• Engage patient in treatment
  – Reinforce importance of recovery
• Support realistic view of change (baby steps)
• Acknowledge difficulties of change
• Help I.D. new (+) reinforcers of change
• Scheduled follow-up (written/electronic homework)
Cognitive-Behavioral Interventions

- Patient education
- Coping skills training
- Reframing, cognitive reappraisal
- Relaxation, imagery, hypnosis, biofeedback
- Pacing activities, exercise
- Structured support
- Caring presence
Enhancing Self Efficacy

• Skill mastery
• Know sensory experience
• Lower arousal
• Sharing vicarious experiences
• Verbal persuasion

**ACT:** Experience Thoughts & Feelings

- Detect
  - Know a thought or feeling is present
- Register
  - Understand the message / experience
- Believe / heed
  - Take the experience as true
- Accept it without judgment
  - Be here and now ... do the best you can
MAINTENANCE STAGE

• Accomplished change through focused efforts
• Varying levels of long term vigilance
• May be “losing” ground
  – due to slips
  – decreasing focus toward commitment
• Lifestyle change ~enhance relapse possibility
Strategies for Maintenance Stage

• Assist in identifying and utilizing drug-free sources of pleasure / comfort *(new reinforcers)*
• Support continued lifestyle changes
• Affirm resolve & Self-efficacy
• Develop a relapse plan
• Review long-term goals
RELAPSE IS A REALITY IN CHRONIC ILLNESS

COMPARISON OF RELAPSE RATES BETWEEN DRUG ADDICTION AND OTHER CHRONIC ILLNESSES

- Drug Addiction: 40 to 60%
- Type 1 Diabetes: 30 to 50%
- Hypertension: 50 to 70%
- Asthma: 50 to 70%
STRATEGIES FOR RELAPSE

• Assist in re-entry to change cycle
• Commend willingness to reconsider positive change
• Relapse as a learning opportunity
  – Examine meaning and triggers
• Assist to develop coping strategies
Who Does the Patient Need?

• Non-judgmental patient-centered team
• Specialty care & support
• A medical home
• A Nurse Advocate
  – Skilled in Pain Assessment
  – Skill in Assessing Substance Use