Managing Chronic Pain in Patients with Substance Misuse / Addiction

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AMERICAN SOCIETY FOR Pain Management Nursing

PCSS-O Training
Prescribers' Clinical Support System for Opioid Therapies

The Perfect Storm of Controversy

- **Persistent Pain Hurts**
  - Needless suffering
    - 100 million in U.S. with chronic pain
      - > DM, HD, CA (combined)
      - 20-30% treated /opioid
    - >$600 billion/year in healthcare/disability
  - Opioids combined with other treatments ~ help
    - Think, feel, do better

- **Opioids Hurt**
  - Rx Drug misuse & addiction disorder
    - 5 million non-medical users
    - $73 billion/year
    - Most common
      - Poisoning type
      - Overdose death
    - "Gateway" drugs

IOM, 2011; SAMHSA, 2011

From: **Extramedical Use of Prescription Pain Relievers by Youth Aged 12 to 21 Years in the United States: Title and subTitle BreakNational Estimates by Age and by Year**

Arch Pediatr Adolesc Med. 2012;():1-5. doi:10.1001/archpediatrics.2012.209

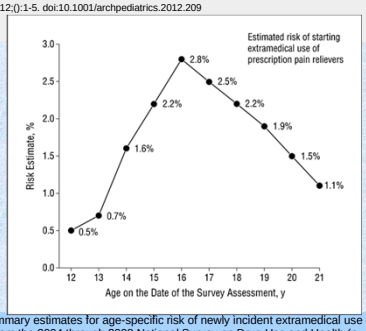


Figure. Meta-analysis summary estimates for age-specific risk of newly incident extramedical use of prescription pain relievers. Data are from the 2004 through 2008 National Survey on Drug Use and Health (n = 119 877).

Problems of Prescription Opioid Use

- 5million non-medical Rx opioid users
  - 66% obtained medicine from family or friend
    - 80% obtained from a single prescriber
    - 75% "borrowed" drug instead of seeking healthcare
  - 69% used to control pain of common ailments
  - 35% "abused" or "dependent" on the drug
- Addiction, Misuse, Abuse, Something else?

SAMHSA, 2011; Boyd, et al. 2006; CASA, 2011

The Intersection of Pain and Problematic Opioid Use

- ~40% on Chronic Opioid Therapy (COT) have problematic drug-use behaviors
  - Aberrant Rx-taking behaviors / non-adherence
  - Fewer have prescription opioid misuse disorder
  - 2-5% have the disease of addiction
- Failure to identify concurrent pain/addiction
  - Undermines ability to treat either effectively

Webster & Webster, 2005; Gourlay, Heit & Almahrezi, 2005

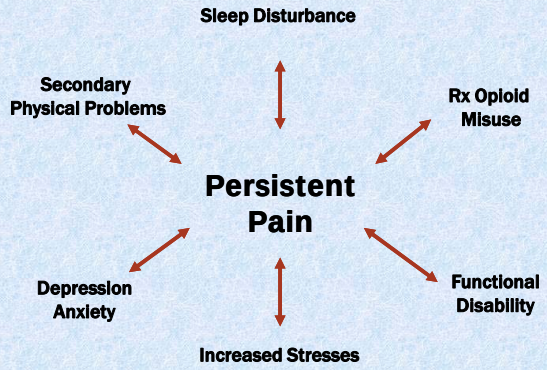
Problem Yes … Epidemic … ?

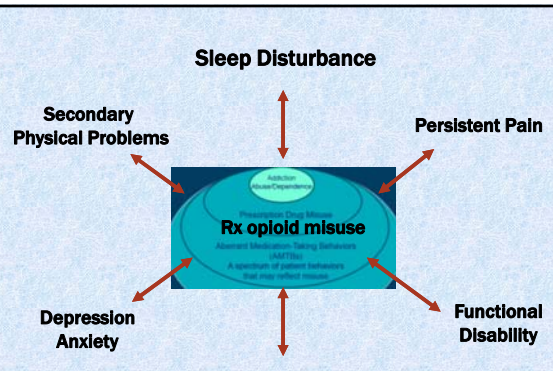
- 15,000 Rx opioid deaths/yr
- Fatal single drug poisonings (2009 data)
  - 441 deaths from pain relievers with
    - 31% of them related to nonprescription analgesics
    - 60-80% of prescription opioids were obtained from non-medical sources or were not used as prescribed
    - Thus if 1 drug used 99% Rx opioids were non-lethal
    - Intentional vs. unintentional can't be determined
  - Rise in Rx opioid deaths has leveled for 5 yrs

CDC, 2011; Poison Control Centers, 2009

Mistaken Beliefs / Unrealistic Fears?

- Patient is just "drug-seeking" to get high
  - Patients may be seeking relief
- Don't want to cause an addiction
  - No single cause of addiction
- Don't want to worsen addiction
  - Withholding treatment worsens all disorders
- Addicted patients can't take opioids
  - Many can with proper dose/supervision





Thus, addiction & chronic pain

- Are major public health concerns
- Involve changes in brain structure/function
- Carry a stigma that is a barrier to treatment
- Can be worsened by stress
- Are poorly understood
  - By friends, family,
  - By the health system & policymakers

Treating only one problem is a reason for relapse

- Treating pain but not depression fails
- Treating depression but not pain fails
- Treating pain not addiction fails
- Treating addiction not pain fails
- Growing appreciation for:
  - Link between comorbidities,
  - Psychosocial factors
  - Treatment failures

Caldeiro et al. (2008) *Addiction, 103* : 1996-2005
Christo et al. (2004) *Adv Psychosom Med, 25* :123-137
Compton et al. (2003) *Nrs Clin North Am, 38* : 525-37
Kroenke et al. (2011) *J Pain 12* (9):964-973.
Larson (2007) *Addiction, 752-760.*
Markowitz et al (2010) *J. Psychoactive Drugs 42* : 193-8

Addiction Refined Definition

(ASAM 2012)

- Brain disease characterized
  - Inability to consistently **A**bstain,
  - Impaired **B**ehavioral control,
  - **C**raving,
  - **D**iminished recognition of significant problems with one's behaviors and interpersonal relationships
  - **D**ysfunctional emotional response.

Ethical Rx of Pain & Addiction

- Beneficence vs. non-maleficence
- Paternalism vs. autonomy
- Justice and respect for persons
- Declaration of Montreal
  - Recognizes the intrinsic dignity of all persons
  - Withholding of pain treatment is profoundly wrong, leading to unnecessary suffering which is harmful…

IASP (2010); ASPMN (2002) revision expected 2012

Opioids can be used for chronic pain patients with addiction

- 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

When Patients have Addiction and Pain Judge the Treatment, Not the Patient!

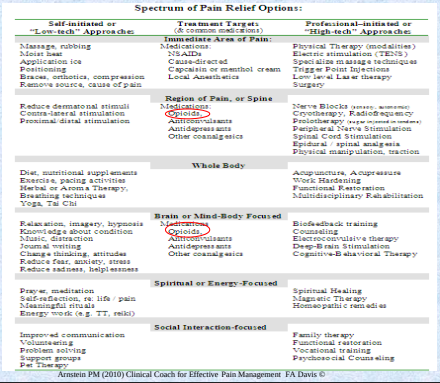
DETERMINE …

- Do the benefits outweigh the risks to the patient and society?
- Is functioning affected?
  - Better or worse with med?
    - Physical
    - Mental
    - Social

NOT …

- Is the Patient good or bad?
- Does the patient deserve meds?
- Should the patient be punished or rewarded?

Multimodal Therapy: Active & Passive approaches to multiple targets



Spectrum of Pain Relief Options:

Self-initiated or "Low-tech" Approaches	Treatment Targets (& common medications)	Professional-initiated or "High-tech" Approaches
	Immediate Area of Pain:	
Massage, rubbing Moist heat Application ice Positioning Braces, orthotics, compression Remove source, cause of pain	Medications: NSAIDs Cause-directed Capsaicin or menthol cream Local Anesthetics	Physical Therapy (modalities) Electric stimulation (TENS) Specialize massage techniques Trigger Point Injections Low level Laser therapy Surgery
	Region of Pain, or Spine	
Reduce dermatonal stimuli Contra-lateral stimulation Proximal-distal stimulation	Medications: Opioids Anticonvulsants Antidepressants Other coanalgesics	Nerve Blocks (epidural, sympathetic) Cryotherapy, Radiofrequency Prolotherapy (helps strained ligaments) Peripheral Nerve Stimulation Spinal Cord Stimulation Epidural / spinal analgesia Physical manipulation, traction
	Whole Body	
Diet, nutritional supplements Exercise, pacing activities Herbal or Aroma Therapy, Breathing techniques Yoga, Tai Chi		Acupuncture, Acupressure Work Hardening Functional Restoration Multidisciplinary Rehabilitation
	Brain or Mind-Body Focused	
Relaxation, imagery, hypnosis Knowledge about condition Music, distraction Journal writing Change thinking, attitudes Reduce fear, anxiety, stress Reduce sadness, helplessness	Medications: Opioids Anticonvulsants Antidepressants Other coanalgesics	Biofeedback training Counseling Electroconvulsive therapy Deep-Brain Stimulation Cognitive-Behavioral Therapy
	Spiritual or Energy-Focused	
Prayer, meditation Self-reflection, re: life / pain Meaningful rituals Energy work (e.g. TT, reiki)		Spiritual Healing Magnetic Therapy Homeopathic remedies
	Social Interaction-focused	
Improved communication Volunteering Problem solving Support groups Pet Therapy		Family therapy Functional restoration Vocational training Psychosocial Counseling

Arnstein PM (2010) Clinical Coach for Effective Pain Management FA Davis ©

Goals of Therapeutic Encounters

- 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
- 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

Nyamathi AM, et al. (2011). *J Addict Dis, 30* (1):6-16
Ducharme LJ et al. (2010). *Am J Addict. 19* (6):496-503
Verhoeven K, et al. (2010). *Pain, 149* (2):229-34.
Van Damme S, et al. (2012) *Pain, 153* (4):800-4

Getting Foundation of Motivators

- **O**pen ended questions re: drug/ nondrug Rx
  - Good things about opioid use?
  - Down side of opioids?
- **A**ffirmation of strengths
- **R**eflection of core values
  - ..what would you be doing a year from now?
- **S**ummary

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
  - Emotional arousal

CONTEMPLATION

(best time for Motivational Interview)

- Demonstrates willingness to discuss, read 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" the decisional balance toward change
- SMART GOALS:
  - **S**pecific (Significant, Simple)
  - **M**easurable (Motivational, Manageable)
  - **A**ttainable (Achievable, Actionable, Acceptable)
  - **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 and strategies for change
- Offer variety of options for change & treatment
- Identify & plan to overcome barriers to change
- Elicit what has worked in the past
- Assist with issues / barriers:
  - Finances, transportation, child care, work
  - Other potential barriers

CBT as a treatment strategy

- Change mindset
  - Pain/craving is bearable
  - Can be resourceful and creative
  - Need to take action to solve problems
- Monitor & recognize behavior patterns
  - Thoughts, feelings & actions are linked

CBT treatment goals

- Teach timely adaptive coping
- Practice and master skills
- Positive reinforcement for efforts
- Rehearse / plan for future use of skills
- Plan for relapse prevention/management
  - Slips and falls

Kwekkeboom et al (2010) *J Pain Symptom Manage. 39*(1):126-38.
McCracken & Turk (2004) *Spine, 27* (22):2564-73.
Hoppes (2006). *CNS Spectrum, 11* (11):829-51
Waldron & Kaminer (2004). *Addiction, 99 Suppl.2*:93-105.

Cognitive-Behavioral Interventions

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

Perceptions to Challenge

- Half-truths / Self-defeating thoughts
- Mind-reading / Fortune-telling
- Exaggerated thinking, catastrophizing
- Pessimistic, hopeless / helpless thoughts
- Blaming a single person / event
- Self-pity … why me?! ….
- Things can be the same … if only ….

Perceptions to validate

- Your chronic pain, substance misuse and/or addictive disease are real problems
- You are responsible for participating in your pain...
- You can cope
- You did the best you could do at that time … can you learn to do better?

Key to successful CBT: Enhancing Self Efficacy

- Skill mastery
- Knowledge about sensory experience
- Lower arousal
- Sharing vicarious experiences
- Verbal persuasion

Wells-Federman et al. (2002). *Pain Management Nursing.* , 3 (5): 141-153.
Litt et al. (2008). *Addiction, 103* (4):638-48.

ACTION

- Behavior change as planned
- Tracks the behavior being changed
- Commits to identify / overcome obstacles
- Vulnerable to abandoning 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 in early stage of change
- Help identify new reinforcers of positive change
- Scheduled follow-up (written/electronic homework)

Acceptance & Commitment Therapy

- Pain &/or suffering is a normal part of life
- Stop fighting to get rid of pain
- Don't do the things that make it worse
- Types of pain can be distinguished
- Pain ~ mandatory, but suffering is optional

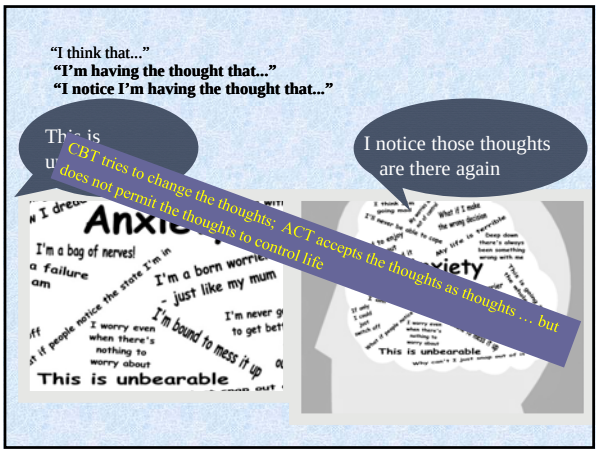
Vowles KE, et al. *Behav Res Ther, 49* (11):748-55.
Wild , et al. (2006). *Addict Behav. 31* (10):1858-72.

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

ACT: How it differs?

- CBT focuses more on thought than action
- ACT focuses more on the behavior / actions
  - ACT may explore the values and how thoughts keep the person "stuck"
  - Focus is the actions … being the best you can be
- CBT may be past or future focused
  - ACT is present focused



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

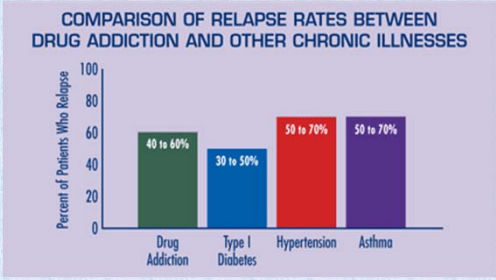
- Assist in identifying and utilizing drug-free sources of pleasure / comfort (new reinforcers)
- Support continued lifestyle changes
- Affirm resolve & Self-efficacy
- Develop a relapse plan
- Review long-term goals

Relapse: A Real Concern

- Of concern to both patient & caregivers
- Risk factors:
  - Drug exposure
  - Unrelieved pain
  - Anxiety
  - Interactions with professionals that negatively impact self-image
  - Lack of a support system that can respond to need
- Collaborate with patient to develop a "relapse plan" ahead of time

(Volkow, NIDA, 2007)

RELAPSE IS A REALITY IN CHRONIC ILLNESS



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 in developing coping strategies

Thank you!

Please save the date for our next webinar!

Wednesday, June 27, 2012 12:00-1:00pm CT

Topic: Adolescent Case Management: Pain and Opioids

Speaker: *Helen N. Turner, DNP, RN-BC, PCNS-BC, FAAN* - Clinical Nurse Specialist, Assistant Professor; Pediatric Pain Management Center; Doernbecher Children's Hospital; Oregon Health & Science University; Portland, Oregon

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