AMERICAN SOCIETY FOR Pain Management Nursing

ASPMN Position Statement
Pain Management in Patients with Addictive Disease

The American Society for Pain Management Nursing (ASPMN) position is that patients with addictive disease and pain have the right to be treated with dignity, respect, and the same quality of pain assessment and management as all other patients. This includes maintaining a balance between provision of pain relief and protection against inappropriate use of prescribed medications. Nurses are well positioned and obligated to advocate for pain management across all treatment settings for patients actively using alcohol or other drugs, patients in recovery, or those receiving methadone for opioid dependence.

Background:
Addiction is a chronic, relapsing, and treatable disease. It is characterized by a lack of control over consumption and compulsive use despite harmful consequences. These factors challenge the safe and successful management of pain in the addicted patient. Research in addiction medicine reveals a strong association between stress and drug craving. The stress of unrelieved pain may contribute to relapse in the recovering patient or increased drug use in the patient who is actively using.

A nationwide sample of more than 20,000 adults estimates that more than 16% of the population has experienced or is experiencing a problem with alcohol or drugs (Robins & Regier, 1991). In primary health settings, lifetime alcohol disorders have been estimated at 16% to 28% and 7% to 9% for drug disorders (Fleming & Barry, 1992). Considerable research has linked alcohol and drug use to major and minor trauma and to chronic illnesses associated with a high pain index (e.g., pancreatitis, head and neck cancers) (Miller, Lestina, & Smith, 2001; Soderstrom, Cole, & Porter, 2001).

Despite the increased risk of painful disorders, there is abundant evidence of under treatment in addicted patients. Too often a patient's request for more or different medications is erroneously assumed to be addiction, and the possibility of undertreated pain is not explored (Breitbart, 1993; Iocolano, 2000; Portenoy & Payne, 1992; Wesson, Ling, & Smith, 1993).

Definitions:
Addiction: A primary, chronic, neurobiologic 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).

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).

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, APS, ASAM, 2001).

Pseudoaddiction: An iatrogenic syndrome created by the undertreatment 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 (Weissman & Haddox, 1989).

Physical dependence, tolerance, and addiction are separate phenomena but may co-exist. It is important to distinguish tolerance and physical dependence from addiction. These phenomena require assessment, planning, intervention, and evaluation that are specific to the clinical circumstances and to the individual experiencing them.

Ethical tenets:
The ethical principles of beneficence (the duty to benefit another) and justice (the equal or comparative treatment of individuals) oblige healthcare professionals to manage pain and provide humane care to all patients, including those patients known or suspected to have addictive disease. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) states, "Patients have the right to appropriate assessment and management of pain" (Standard RI.1.2.8, JCAHO, 2000). The American Hospital Association (AHA) Patient Bill of Rights states that all patients have the right "to considerate and respectful care" (AHA, 1972, p.1). The use of stigmatizing terms such as "junkie" or "drug seeking" create prejudice, bias, and barriers to care (AHA, 1972; Caine & Hammes, 1994; Thompson, 1996.)

Recommendations:
The recommendations below begin with those that apply to *all* patients with addictive disease and are followed by additional recommendations specific to patients who are actively using, in recovery, or receiving methadone maintenance

Recommendations for *all* patients with addictive disease:

- Identify and use resources available to assist with the diagnosis and treatment of both addiction and pain.
- Encourage the patient to use support systems (e.g., family, significant others, or rehabilitation sponsor); offer additional resources (e.g., addictions counselor).
- Involve the patient in pain management planning and, with the patient's consent, include family and significant others.
- Provide the patient with verbal and written information about the pain management plan, including what the patient can expect from caregivers and what the patient's responsibilities are.
- Ensure consistency in the implementation of the pain management plan.
- Educate the patient, family, and significant others about the differences between addiction, physical dependence, and tolerance.
- Help the patient make informed choices about medications by educating the patient, family, and significant others about medication options.
- Select and titrate analgesics based on pain assessment, side effects, and function, as well as sleep and mood.
- Be prepared to titrate opioid analgesics and benzodiazepines to doses higher than usual. The patient may have developed tolerance to some medications, or drug use may have caused increased sensitivity to pain.
- Benzodiazepines, phenothiazines, or other sedating medications that do not relieve pain should not be used as substitutes for analgesics.
- If pain is present most of the time, provide analgesics around-the-clock (ATC).
- Use the oral route and long acting analgesics when possible.
- Consider the use of IV or epidural patient-controlled analgesia (PCA) for acute pain management.
- Record and discuss with the patient any behavior suggestive of inappropriate medication use, especially of controlled substances.
- When opioids, benzodiazepines, or other medications with a potential for physical dependence are no longer needed, taper them very slowly to minimize the emergence of withdrawal symptoms.
- Consider nonpharmacological methods of treatment for pain but do not use them in place of appropriate pharmacological approaches.

Recommendations for patients who are actively using, in addition to the recommendations for *all* patients with addictive disease:

- Distinguish between pseudoaddiction and addiction. This may be difficult in the presence of unrelieved pain.
- Assess for and treat symptoms of withdrawal from alcohol or other drugs. **
- If the patient acknowledges inappropriate use of prescribed medication or non-prescribed substances, openly discuss this and encourage the patient to express any fear of how this may affect pain management and treatment by staff.
- Assess for psychiatric co-morbidity (e.g., anxiety, depression) and obtain treatment if needed.
- If the patient is physically dependent on morphine-like opioids, do not treat pain with an opioid agonist-antagonist (e.g., nalbuphine, butorphanol, buprenorphine, pentazocine) because it will precipitate acute withdrawal.
- Once pain is controlled, provide information on treatment options for addictive disease. **

Recommendations for patients in recovery, in addition to the recommendations for *all* patients with addictive disease:

- Explain any intent to use opioids or other psychoactive medications.
- Explain health risks associated with unrelieved pain, including increased risk for relapse. **
- Encourage patient, family, and significant others to discuss concerns about relapse, and offer assistance.
- Respect the patient's decision about whether or not to use opioids or other psychoactive medications. Reassure the patient that other methods of pain relief (e.g., NSAIDs, regional, local anesthetics) can be used if the patient prefers not to use opioid analgesics.
- Encourage active participation in recovery and maintenance efforts.
- Establish a therapeutic plan for relapse.
- If relapse occurs, intensify recovery efforts; do not terminate pain care.

Recommendations for patients on methadone maintenance treatment, in addition to the recommendations for *all* patients with addictive disease:

- Initiate and continue regular discussion with methadone treatment providers about the pain management plan.
- Methadone doses used for methadone maintenance in the treatment of opioid addiction should be continued but are not relied upon for analgesia. When opioid analgesics are appropriate for pain management, two options are available

1. Add another opioid on an ATC basis, or
2. Give additional methadone doses. Methadone given for analgesia requires more than once a day dosing.

The above recommendations have been influenced by the works of Compton, 1999; Dunbar & Katz, 1996; Grinstead & Gorski, 1997; Heit, 2000; Portenoy & Payne, 1992; McCaffery & Vourakis, 1992; Tucker, 1990.

** Visit the ASPMN Web site (www.aspmn.org) for assessment tools for withdrawal, protocols for treatment of withdrawal, risks of unrelieved pain, treatment options for addictive disease, and therapeutic plans for relapse.

Summary

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. Nurses are in an ideal position to advocate and intervene for these patients across all treatment setting**.**

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Suggested Readings

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Schadelbauer, C., Katz, M., & Chapman, M. (2001). *Drug Enforcement Administration (DEA), 21 health groups call for balanced policy on prescription pain medications like OxyContin: Goal is to protect legitimate use of prescription drugs for patients in pain.*Washington, DC. (DEA press release, October 23).

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Harmful Effects of Unrelieved Pain
Table 2.2: Harmful Effects of Unrelieved Pain, Page 24, From: Pasero, C., Paice, J.A., & McCaffery, M. (1999). Basic mechanisms underlying the causes and effects of pain. In M. McCaffery, & C. Pasero, *Pain: Clinical manual* (2nd ed., pp. 15-34). St. Louis: Mosby.

Assessing and Treating Symptoms of Withdrawal
Alcohol Detoxification Protocol, Page 456, From: Cummings, P. (1999). Substance Abuse. In M. McCaffery, & C. Pasero, Pain: Clinical manual *(2nd ed., pp. 428-466). St. Louis: Mosby.*

Addiction Research Foundation Clinical Institute Withdrawal Assessment -Alcohol
(CIWA-Ar), Page 457, From: Cummings, P. (1999). Substance Abuse. In M. McCaffery, & C. Pasero, *Pain: Clinical manual* (2nd ed., pp. 428-466). St. Louis: Mosby.

Detecting Alcoholism: CAGE Questionnaire, Page 705, From: Pasero C, Reed B,
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Therapeutic Plans for Relapse
Grinstead, S. F., & T. T. Gorski (1997). Addiction-Free Pain Management. *Independence, MO, Herald House/Independence Press. (The entire workook gives patients a guided, step-by-step approach to relapse prevention. It should be used in conjunction with relapse prevention counseling. Particularly helpful chapters include:*Abstinence Contract and Intervention Planning, *pp 21-26;* Identifying and Personalizing APM/RPC Hight-Risk Situations and Developing a Recovery Plan pp.47-61.

Web Sites for Treatment Options

1. Alcoholics Anonymous
   http://www.alcoholics.anonymous.org
2. American Society of Addiction Medicine
   http://www.asam.org
3. Drug and Alcohol Treatment Referrals
   http://www.DRUGHELP.org
4. Hazelden Information Center (No web resource given).
   Phone: Recovery Services 800-257-7800;
   Publications 800-328-9000
5. Internet Alcohol Recovery Center
   http://www.med.upenn.edu/~recovery
6. Narcotics Anonymous
   http://www.wsoinc.com
7. National Alliance of Methadone Advocates
   http://www.methadone.org
8. National Council on Alcoholism and Drug Dependence
   http://www.ncadd.org
9. National Institute on Drug Abuse (NIDA)
   http://www.nida.nih.gov

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