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Integrated Treatment Chronic Pain and Addictions

Darcy A. Sander

WSU-School of Nursing

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The members of the committee examining the clinical project of DARCY SANDER find it satisfactory and recommend that it be accepted.

Chair: Merry Armstrong, DNS, ARNP _____

Julie Dewitt-Kamada, DNP, PMHNP, BC _____

Randi O'Brien MN, ARNP _____

Abstract

Chronic non-malignant pain (CNMP) decreases success of addictions treatment and increases the relapse rate of substance dependent clients in recovery. Though both pain and addiction specialists advocate for the integration of chronic pain management within substance dependency treatment, few patients have access to such care. The purpose of this paper is to propose a model of care for chronic non-malignant pain and substance dependency using Dorothea Orem's self care deficit theory of nursing.

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Introduction

The International Association for the Study of Pain defines chronic pain as "pain without biological value that has persisted beyond normal tissue healing, (usually taken to be 3 months)" (International Association for the Study of Pain, 2003, p. 1). Prevalence rates of chronic non-malignant pain in the United States are reported between 10.1- 55.2%; women experience more chronic non-malignant pain than men (IASP). Chronic pain affects a patient's employment and relationships (American Pain Foundation [APF], 2008). Significant health care use and co-morbid disorders such as depression, anxiety, substance abuse and dependency are associated with chronic non-malignant pain (Workman, Hubbard, & Felker, 2002). All CNMP patients are vulnerable to undertreatment of pain (Foundation, 2006).

In a study of 801 primary care patients receiving opioids therapy, 3.8% had an opioid disorder per DSM IV criteria (Fleming, 2007) while approximately 3-26% of the general population have an addictive disorder (Rosenblatt, 2005). Standard diagnostic criteria such as the DSM-IV are difficult to apply to patients with chronic non-malignant pain who are using therapeutic opioids. Prescribed opioid use may not lead to legal, employment, family and social consequences that are generally associated with substance abuse (Compton, 2008) and the objective criteria of tolerance and dependence are to be expected with long term use. Additional prevalence studies for co-morbid chronic non-malignant pain and substance dependency with addiction characterized by the four C's " impaired Control over use of drug, Compulsive drug use, Continued drug use despite harm, and unmanageable drug Craving" and (Academy of Pain Medicine, 2001)American Pain Society and the American Society of Addiction Medicine (2001) may reveal differences in prevalence from that in Fleming's study (2007). .

Though treatment professionals who have derived principles of pain medicine have addressed concerns of prescribing opioids to persons with CNMP, undertreatment of CNMP remains an issue (Portenoy, 1999). Particularly at risk are patients with a history of or current active addictive disorder (Webster, 2007). Pain and addiction medicine experts have developed models of care and tools for the assessment of addiction risk and aberrant behaviors. Since unrelieved pain may decrease success of substance dependency treatment as well as lead to relapse, specialists in pain and addiction medicine recommend that CNMP and substance addiction be treated concurrently (Clark, Stoller, & Brooner, 2008; P. Compton, & Athanasos, P., 2003; Webster, 2005). To assist with this goal, pain and addiction experts have developed models of care and tools for assessment of addiction risk and aberrant behaviors. Despite agreement of concurrent treatment CNMP and substance dependency, it isn't clear that this has become standard of practice. Communication with Compton (Compton, P., personal communication, 11/13/2009), a leading nurse researcher in opioids and addiction, indicated agreement with the assertion that a gap exists in the literature for inpatient treatment of CNMP and substance dependency.

The 2005 DASIS report (Office of Applied Studies, 2007) showed that out of 13,371 reporting substance abuse treatment facilities none indicated treatment of co-occurring substance abuse and chronic non-malignant pain though many reported special programs. In one study of CNMP in methadone maintenance and residential facilities, 37% of patients in the residential treatment program experienced CNMP (Rosenblum, 2003) though it wasn't clear whether the study participants may have been experiencing hyperalgesia (heightened pain sensitivity after long term opioid use). A survey administered to 79 participants in an outpatient substance abuse treatment program discovered that 26.1% of patients experienced severe

chronic pain; the same study revealed that while 72% of the patients had expressed interest in pain management only 13% were receiving treatment for management of chronic pain (Sheu, 2008). There appears to be a significant gap in treatment for patients with co-morbid chronic non-malignant pain and substance dependency.

Statement of Purpose

The purpose of this paper is to propose a model of care for concurrent chronic non-malignant pain and substance dependency using Dorothea Orem's self care deficit theory of nursing.

Self-Care Deficit Theory

Nursing theorist Dorothea E. Orem (McEwan & Wills, 2002, p137) proposed three nested theories: self-care, self-care deficit and nursing system that comprise Orem's Self-care Deficit Theory of Nursing (S-SCDT). The theory of Self-care includes concepts of: self-care, therapeutic self-care demand, self-care agency, and self-care requisites. The theory of self-care deficit defines when nursing is needed and identifies methods of nursing assistance. Nursing system explains the relationship between patient and nurse actions. As well, nursing system provides a plan of care for the patient (currentnursing.com, 2009; de Chesnay, 2008; Hartweg, 1991; Orem, 1995).

Theory of Self-Care

Self-Care.

Orem (1995, p.8) defined self-care as " personal care required each day by individuals to regulate their own functioning and development" (Orem, 1995, p.8). Orem (1995) continues to describe self-care as both a voluntary and learned right and responsibility. Self-care consists of deliberate actions that individuals perform either on their own behalf or on behalf of their dependents to maintain health, well-being, or life (Orem, 1995). Self-care actions are either

internally or externally motivated. Internally motivated actions are actions that occur from self-motivation, self-awareness, acquired knowledge and interest. Externally motivated actions are actions that seek independent knowledge, use external equipment and or supplies, or that control external factors in the environment (Orem, 1995).

Therapeutic self-care demand.

Therapeutic self-care demand is the totality of the self-care needs. Self-care deficit occurs when the self-care demands or needs of an individual are beyond the self-care agency (Hartweg, 1991).

Self-care agency.

Persons who engage in their own self care are described as having their own power or self-care agency (Orem, 1995, p, 103).

Self-care Requisites.

Self-care requisite "signifies a specific need for regulation of human functioning and development" (Orem, 1995, p. 12). Self-care requisites are universal, developmental, or health deviation. Universal requisites are needed by all humans and include food, water, and air. Developmental requisites are associated with conditions throughout the lifespan or life events such as pregnancy or a death in the family. Genetic or functional deviations are associated with health deviation requisites

Theory of Self-Care Deficit or Dependent Care Deficit.

Adults require self-care assistance if unable to meet their own needs for life or promotion of health. Infant, child, adolescent and the aged all require self-care assistance; theory of self care deficit for infant, child, adolescent and the aged is called dependent self care deficit theory of nursing (Orem, 1995).

Theory of Nursing System

Types of nursing systems.

The interaction required between nurse and patient is dependent upon the patient's ability to perform self-care actions. Nursing system is of 3 types: wholly compensatory, partly compensatory, and supportive-educative (Hartweg, 1991; Orem, 1995).

Methods of Assisting.

In everyday life people help one another to deal with needs and concerns. Orem (1995) describes the methods that nurses use to assist people with overcoming or compensation of health-associated limitations. Orem identified five helping methods; helping methods are a series of actions and are "1)acting for or doing for another, 2) guiding and directing, 3) providing physical or psychological support, 4) providing and maintaining an environment that supports personal development, 5) teaching" (Orem, 1995, p. 15).

Professional health service and nursing system

Orem (1995) identifies professional health service and nursing system operations as diagnostic, prescriptive, treatment or regulatory, and case management. In diagnostic operations relevant data to the presenting health issue is collected whereas prescriptive operations is the course of action chosen for the diagnosis made. Treatment or regulatory operations is the activities taken for the course of action, and case management operations combines all of the previous operations to ensure the optimal use of health services.

Nursing system operations complete the same processes of diagnosis, prescriptive, treatment or regulatory, and case management operations; nursing system operations includes interpersonal relationships (Orem, 1995). In the nursing system, the nurse diagnose clients self-care deficit, prescribes nursing actions and completes prescribed medical actions, designs

and assists patient with the treatment and regulation of patient's self-care needs, and provides a case management plan of care for the patients self-care needs now and into the future.

Orem's theory of self-care has been applied to patients with arthritis, pain and analgesia (McEwen, 2002). The process of recovery and the process of learning pain management techniques for pain control falls under Orem's self care of a learned deliberate action that goes through phases of growth (Hartweg, 1991). The S-CDTN specifically addresses learning to accept particular states of health and living with effects of medical conditions with the modification of "self concepts in accepting oneself as being in a particular state of health" (currentnursing.com) Chronic non-malignant pain and substance dependency limit an individual's ability to manage their own health. Orem's theory of self-care deficit is applicable to patients with either or co-occurring disorders of CNMP or substance dependency; health deviation self care requisite is a developmental self care requisite in which self care includes seeking out medical care, the application of knowledge of care and learning to live with conditions of illness, injury, or disease (currentnursing.com).

In order to apply a model of care using the self-care deficit theory of nursing, nurses must be knowledgeable in standards of care in both health services and nursing care. Nurses also need to be able to apply diagnosis, prescriptive, treatment and regulatory, and case management operations of both health services and nursing to patient care. The subsequent literature review discusses significant literature of chronic non-malignant pain and substance dependency in connection with the Self-Deficit Theory of Nursing.

Literature Review

Nursing Diagnosis

Orem nursing diagnosis Basic Conditioning Factors BCFs

The process of nursing diagnosis (Orem, 1995) includes gathering and investigation of patient's self care agency and patient's therapeutic self-care demand. Basic conditioning factors (BCFs) are elements of personality or environment that impact self-care requirements and self-care abilities (Geden, 2001). Basic conditioning factors include,

> *1)age*
> *2)gender*
> *3)health state*
> *4)sociocultural orientation*
> *5)health care systems factors; for example, medical diagnostic, and treatment modalities*
> *7)family system factors*
> *8)pattern of living including activities regularly engaged in*
> *9) environmental factors*
> *10) resource availability and adequacy (Orem, 1995, p. 203).*

Basic conditioning factors influence self-care requirements and self-care abilities, and may influence or affect a patient's ability for action(Geden, 2001). In addition to assessing basic conditioning factors, foundational capabilities and dispositions are considered as central to a person's ability to move into action (Geden, 2001). A nursing assessment of foundational capabilities and dispositions includes basic conditioning factors as well other factors including factors related to self-awareness, goals sought, previous success with self-care, self-acceptance, and ability to perform self-care activities due to factors such as memory or learned skills (Orem, 1995).

Assessment of Pain

Since the biopsychosocial theory of CNMP considers that both physiobiologic and psychosocial factors contribute to the development and course of CNMP (Finestone, Alfeeli, & Fisher, 2008; Stanos, 2007; Vlaeyen, Crombez, & Gourbet, 2007) a nursing assessment of basic

conditioning factors, foundational capabilities and dispositions is appropriate in the chronic non-malignant pain patient. Pain assessment includes the quality, intensity, and location of the pain (Smith, 2001) and a psychosocial evaluation (Pujol, 2007). Psychosocial factors include pain belief systems (Pujol, 2007), and "age, sex, severity of pain, psychosocial problems, unemployment, and compensation" (Tunks, 2008). Assessment of the quality, intensity, and location of pain may be done with a variety of pain assessment tools. The visual analog or numerical rating scales provide a onetime look at degree of pain (Pujol, 2007) but may be used several times and used for treatment evaluation. One mnemonic available is "LOCATE;

L- the exact Location of the pain and whether it travels to other body parts
O- Other associated symptoms such as nausea, numbness, or weakness
C- the Character of the pain, whether it's throbbing, sharp, dull or burning
A-Aggravating or Alleviating factors, what makes the pain better or worse?
T- the Timing of the pain, how long it lasts, is it constant or intermittent?
E-the Environment where the pain occurs, for example, while working or at home" (letstalkpain, 2010).

This mneumonic, and the visual and numerical rating scales are easy to use, and would be easy to use within an inpatient setting on a substance dependency unit.

Practice foundational capabilities and dispositions

Self-care deficit theory includes concepts of "self-care as learned behavior and self-care as deliberate action"(Hartweg, 1991). The Pain Stages of Change Questionnaire (Williams, 2007) is a pain questionnaire developed based upon the stages of change (Miller, 2002) that has been used widely in substance dependency care and could assist nurse to assess client's readiness to change in self care of pain management. Coping strategies that might be targeted during treatment can be assessed with the chronic pain coping inventory (Hadjistavropoulos, 1999). The quality of life scale measures a person's ability to function and may take a patient's self- focus off of the pain being felt (Association, 2010). These tools could be incorporated into the substance dependency severity and placement criteria interview to provide a thorough

assessment of foundational capabilities which would include self-awareness and acceptance of health state.

Nursing diagnoses

Nursing diagnoses for the CNMP patient in substance dependency treatment could include self care deficits in any of the eight universal self-care requisites, and is a health care deviation. One nursing diagnosis that could be applied to patients in substance dependency treatment with co-occurring CNMP is, Readiness for enhanced Self-Care (Ackley, 2011; Carpenito-Moyet, 2010) a NANDA approved diagnosis defined as the "pattern of performed activities for oneself that helps to meet health related goals and can be strengthened" (Ackely, 2011, p. 706). Additional self-care deficit nursing diagnoses appropriate to chronic non-malignant pain and substance dependency would be: maintenance of a balance between activity and rest, maintenance of a balance between solitude and social interaction, prevention of hazards to life, functioning and well-being, and promotion of normalcy. (Orem, 1995).

Nursing diagnosis and nursing prescriptive actions are fluid operations. While assessing a client and making a diagnosis the nurse is becoming aware of possible nursing prescriptions. The nurse determines whether nursing diagnosis and prescriptive operations need to be wholly compensatory, partly compensatory, or supportive-educative based upon the basic conditioning factors, foundational capabilities and dispositions of the client (Orem, 1995). Since prescriptive operations are both nurse and health service prescribed, nurses must be aware of both nursing and health service standards of care for nursing diagnosis and the medical diagnosis. The next section discusses both nursing and medical prescriptive actions including guidelines of care for the patient with co-occurring CNMP and substance dependency.

Health Service and Nursing Prescriptive Operations

Health service prescriptive operations are defined as courses of action to be taken with a particular diagnosis. Nursing prescriptive operations describe the actions required to meet self care requisites within the context of the interpersonal relationship of nurse to patient (Orem, 1995). In 2002, the American Society for Pain Management Nursing published a position statement that the patient with CNMP and substance dependency has the "right to be treated with dignity, respect, and the same quality of pain assessment and management as all other patients" and to provide treatment options for addictive disease once pain is controlled. (www.aspmn.org). Health service operations has issued evidence based guidelines for the administration of opioids to patients with substance abuse and dependency and chronic non-malignant pain have been developed (Chou, Fanciullo, Fine, Adler, Ballantyne, Davies, et al., 2009; Trescot, 2008).

Prater, Zylstra, & Miller (2002) specifically addressed the addicted patient in recovery, who could have self care deficit with any of the universal and health requisites, with the following factors of effective pain management: "1) one physician prescribing all the pain medications, 2) encouraging maintenance of stability at home and at the workplace 3) periodically weaning the patient form the pain medication to assess the pain syndrome and level of function, 4) reducing opiod use to the minimum dose necessary to effectively relieve pain while maintaining an effective level of function, 5) using nonpsychotropic pain management when possible without sacrificing effective pain relief or level of function, and 6) being aware that increased doses may be required to maintain effective pain relief and/or level of function due of the development of drug tolerance or the progression of the underlying disease"(Prater, 2002, p130). Prater (2002) doesn't specifically address the patient with

CNMP who is inpatient at a substance addiction treatment center though these principles should be applicable to inpatients with an expected extended length of stay.

Prescriptive nursing operations will include collaboration with the patient about the goals of self-care. The nurse and patient will determine what kind of helping method is preferable to patient and most suitable with the patient's basic conditioning factors, foundational capacities and dispositions. For this model of care it is assumed that the patient has capacities enough for the nurse to have an educative supportive role.

Treatment and regulatory operations

Nursing actions for nursing diagnosis of readiness for enhanced self care, maintenance of a balance between activity and rest, maintenance of a balance between solitude and social interaction, prevention of hazards to life, functioning and well-being, and promotion of normalcy would include formalization of a plan of care. The plan of care is a collaborative plan of care that promotes movement toward improvement in self care agency of universal and health deviation self care requisites.

Self management

Self-management programs and strategies have their place in chronic pain management (Reid et al., 2008; Thomas, 2007). Self management tools can be used by both providers with patients or by patients alone. They can be paced individually and directed at the client's need based on the patient's stage of change. Substance abuse professionals and primary care providers including nurses and nurse practitioners may be able to make use of patient friendly resources to use with their clients on both an inpatient and outpatient basis.

Self-management books

Books may be used by individual clients or in a group led by nursing. Books reviewed here were found by recommendation sources of other nurse practitioners, clinics, or through the search of chronic pain books on book sale websites. Though these books have been chosen for inclusion for evidence based references but are limited in that the books themselves haven't been independently researched for efficacy in self-management of chronic pain or chronic pain with substance abuse. Prior to giving or recommending a book to a client it is recommended that the provider reviews the book.

Managing Pain Before It Manages You (Cadill, 2009) takes a holistic approach to pain management. The book takes the reader through the concepts of pain management and instructs the reader about how pain is affected by thoughts, nutrition, exercise, and stress. In addition to the mind-body and body-mind connection the book teaches about the relaxation response. Each chapter has exercises for the reader to work on each idea presented and additional reading recommendations. The book incorporates evidence-based methods of alternatives to opioids for the treatment of pain management though she doesn't directly cite her resources in the text. Additional relaxation information in the form of audio downloads are available in conjunction with this book. Caudill (2009) recommends that the reader use this book to augment communication with their healthcare provider.

Authors Davis, Eshelman, and McKay (2000) in The Relaxation and Stress Reduction Workbook) book offers management of chronic pain with relaxation techniques and cognitive behavioral therapy techniques. By teaching relaxation and cognitive behavioral techniques, the chronic pain patient may reduce their pain by visualization, meditation, self-hypnosis, and coping skills. This book has exercises for the reader to complete and additional readings. The book and chapters do not have clear references to the material, though it may be that the further

readings are indeed the references. This book is the published workbook that the authors, psychologists and a licensed clinical social worker developed through "trial and error" while offering stress management and relaxation workshops in their own practice.

The biopsychosocial model of pain is employed in the book The Chronic Pain Care Workbook (M.J. Lewandowski, 2006) with the use of the Behavioral Assessment of Pain Questionnaire (BAP). This author is a pain specialist with 20 years experience at a university based pain center and co-developed the BAP. Lewandowski explains the BAP distinguishes between the physical components of the pain and the emotional suffering often accompanies chronic pain. This book is divided into four parts: pain basics, how the reader has dealt with the chronic pain and its impact of life, handling setbacks and maintaining gains made in treatment, and the pain scorecard. The book uses current research of current pain management approaches and references are clear.

All of these self-management books are appropriate for use with the cognitively intact substance abuse/addiction treatment CNMP patient. An assessment of readiness to change could be used to determine how the material is presented, either for use in a group setting, one on one, or for the client to read him/herself.

The final goal of operations is that of case management. The nurse who is working with the substance dependent client with co-morbid pain will need to develop a discharge plan that includes outpatient treatment for both substance dependency and chronic non-malignant pain.

Case Management

After discharge from substance dependency treatment the patient with CNMP is at particular risk for relapse (www.aspmn.org). A plan for outpatient follow-up for both pain and substance dependency management should be implemented. While planning for discharge the

nurse or prescriber should attempt to ensure that standards of care for CNMP and substance dependency will be followed or search out an alternative follow-up plan. The patient should also be involved with discharge planning so such that he understands expectations of him upon discharge. Standards of care include both a process for long-term opioid therapy and tools for aberrant behavior screening.

The process for long term-opioid therapy is: an assessment of risk, on-going monitoring, patient contracts, urine drug testing and documentation (Gianutsos &Safrenek, 2008; Stanos, 2007a). These steps are part of the 4 A's of Pain Treament: Analgesia, Activities of Daily Living, Adverse effects, and Aberrant drug taking behaviors and the 10 Steps of Universal Precaution of Pain Medicine (Benedict, 2008; Gourlay, Heit, & Almahrezi, 2005; Stanos, 2007a). Universal precautions were developed for infection control with the realization that it was impossible for a risk assessment to be absolutely reliable. Applied to pain medicine universal precautions, is an assessment and management approach that can be used with all patients thereby reducing bias in patient care, improving patient care, and containment of the legal risks associated with the prescribing of opioid medications (Gourlay et al.2005). For the model of care using the self-care deficit theory of nursing the nurse will need to apply and be aware of these principles of pain management as part of discharge planning.

Concern regarding the complications of long-term opiate use and the fear of patient addiction has led to research of addiction risk and addictive behaviors tools. Screening tools for risk assessment and clinical guidelines have been developed for providers to aid in the decision process of whether to prescribe opioids and to assist with monitoring (Webster & Webster, 2005). Many tools have been developed or used with chronic pain patients: Personality Assessment Inventory (Karlin et al., 2005), Prescription Opioid Misuse Index (Knisely, Wunsch,

Cropsey, & Campbell, 2008), Screening tool for addiction risk (Friedman, Li, & Mehrotra, 2003), Current opioid misuse measure (Butler et al., 2007), Opioid risk tool (Webster & Webster, 2005), Addiction behaviors checklist (Wu et al., 2006), and Pain medication questionnaire (Holmes et al., 2006). The Addictions Behavior Checklist, Current Opioid Misuse Measure, and the Prescription Opioid Misuse Index were all designed to assess for ongoing abuse of opioid medication and therefore could be particularly valuable for discharge planning and ongoing assessment of the patient being discharged from addiction treatment.

The Addictions Behavior Checklist (Wu et al., 2006) is a brief 20 item that tracks behaviors among chronic pain patients. Rather than assessing risk for the misuse of opioids prior to prescribing it assesses ongoing patient behavior through patient interview and observable behaviors. As with the Addictions Behavior Checklist the Current Opiod Misuse Measure (COMM) developed by Butler et al (2007) was developed to assess current behaviors of patients taking opioids. It is a 40 item self-report questionnaire developed with input of pain management and addiction specialists. Knisely et al (2008) used the Prescription Opiod Misuse Index (POMI) which is an eight item interview that centered on prescription use questions including whether the pain medication manages the pain. This is the first study that assessed both prescription misuse and the treatment of the pain. It was done as a structured interview and with a small sample of Oxycontin users. A limitation of these tools is that the validations studies were limited in sample number and sample demographics. The authors of these tools all recommend continued validation studies and that the tools be used as a communication tool between patient and provider rather than an absolute reason to discontinue opioids.

At admission, the Current Opioid Misuse Measure (COMM) and Prescription Opioid Misuse Index (POMI) could be used to begin discussion with a patient about their use of opioid

medications. As a practical matter the Addictions Behavior Checklist (ABC) wouldn't be as useful in the inpatient setting because of the controlled environment. A post-discharge plan should include a plan for pain management with a primary care provider whom will coordinate all aspects of medical care (Chou, et al., 2009). Level of function, level of pain, aberrant behaviors and adverse effects during pain management and opioid therapy should be regularly documented by the primary care medical home. One documentation tool is the Pain Assessment and Documentation tool developed for easy addition to a patients chart and based on the four A's, analgesia, activities of daily living, adverse effects, and aberrant drug-related behavior (Kirsch, 2008). The PADT is available online at painknowledge.org.

Treatment agreements or contracts, sometimes referred to as pain contracts or long-term opioid agreements, are also recommended by many in the field. Informed consent for long-term therapy is included with a treatment agreement (Gourlay., Heit., & Almahrezi, 2005; ASPMN, 2002) and provides clarification and boundaries for the patient and the provider. Treatment agreements provide for informed consent and outline for the patient and provider what will be expected of them during long-term opioid therapy including the use of single provider, single pharmacy, early refills, medication changes, and the use of random urine drug testing. Concerns regarding treatment agreements include termination of patient care when the patient needs assistance the most, ie at time of relapse or time of pain exacerbation. As well, despite common use in practice treatment agreements have not been proven efficacious (Chen, 2008; Rosenblatt, 2005). Treatment agreements should indicate to the patient that the provider is including the patient in the plan of care to relieve the patient's pain while working together to prevent or detect relapse to substance abuse/substance dependency (Compton & Athansos, 2003).

One part of a treatment agreement is random urine drug screening. Urine drug testing is a useful tool for practitioners for monitoring the absence/presence of prescribed medications and for illicit substances (Compton, 2007; Gourlay, 2008). Nurses and prescribers must be knowledgeable regarding the collection process, ordering the screen, and the interpretation of results. Limitations of urine drug screens include that synthetic opioids, for example, aren't routinely included in a urine drug screen. Due to half-life of medications, opioids that break down into metabolites might show as a higher level than was taken. Thus, for patients prescribed opiates, and especially synthetic opiates, urine drug testing needs to include the specific opiate and metabolites prescribed and the interpretation needs to be completed by persons knowledgeable in the toxicology of urine drug testing (Compton, 2007).

The inpatient team can recommend the use of a treatment contract, random urine drug screening, and regular documentation to the follow up provider. The provider may be referred for examples of treatment contracts, informed consent tools, and assessment tools to websites of the American Academy of Pain Medicine (AAPM.org), emergingsolutionsinpain.org, PainEDU.org, and painknowledge.org for examples of treatment contracts, informed consent, and documentation tools. The substance abuse/dependency inpatient team should also have a plan in place to provide to the primary medical home any needed consultations with addiction dependency specialists for clarification and direction if needed.

Websites

Nurses can also inform-support their patients of resources available for continuing to develop their own self care skills. Nurses can provide to clients appropriate internet reference sites in addition to the self management tools that were used while inpatient. Washington, Fanciullo, Sorenson, & Baird, (2008) studied the quality of internet information on chronic pain

websites. The top nine quality websites of chronic pain websites (out of 240) reviewed found by this study were: Aetna Intellihealth, American Pain Foundation, National Institute of Neurological Disorders and Stroke, breastcancer.org, American Chronic Pain Association, WebMd Health, MedicineNet Inc, Family doctor.org,American Academy of Family Physicians, and Our Chronic Pain Mission. Researchers also gave the following guidelines for finding quality websites; 1) use quality websites as listed in the research article, 2) access websites from a main search page, 3) access websites that are designed around standards, and 4) patients should avoid websites that are given in sponsored sections of search pages. Websites can provide additional information to patients, providers, and family about chronic pain, its treatment, and coping strategies thereby potentially enhancing self-care.

The case manager could regularly check in with client to ascertain outcomes of goals in management set by the patient, adherence to treatment plan, and movement towards acceptance of health condition. Case management may or may not be available to patients upon discharge from substance dependency treatment, just as access to treatment of chronic non-malignant pain and substance dependency is a problem. The nurse of the medical home, however, could follow the client and assess patients growth in self-care in connection with regular appointments.

Case Study

Case Study

PJ is a 50 year old married father of twin boys who is admitted to the substance dependency unit for treatment of alcohol dependency after receiving a citation for driving under the influence. Though he has completed inpatient treatment twice in the past 3 years, he states that he never really "worked the program". He takes opioids that are prescribed from his primary care physician ever since he injured his ankle after a roofing accident. He rates his pain as a one or

two when he takes opioids as prescribed. He receives social security disability, is separated from his wife and never sees his children. He lives alone and doesn't talk to family or friends. He states that his activities at home include smoking, watching television and doesn't do any physical activity out of fear that he will "hurt too much". He has never attended any support meetings or outpatient substance addiction discharge treatment.

He hasn't participated in pain management classes available at the clinic where he is followed for pain, nor has he regularly kept scheduled appointments (this was revealed after the SDRU had a case coordination telephone call with his primary provider). Though he states that he functions well he has no other regular activities other than smoking and watching television. When asked about the management of pain he is unable to state anything that he does that makes it worse or better, or the effect of the medication that he has taken other than he "likes the dilaudid the best". Shortly after his admission to the SDRU he declines to go out on an activity because it "will make him hurt too much".

Diagnosis: This client has a nursing diagnosis of self-care deficit. He is not meeting universal requisites of promotion of health, nor is he balancing activity with rest. He has hazards to life with the driving while under the influence nor is he balancing social activity with solitude. Client has a health requisite of substance dependency.

Prescriptive: Currently, the client is ready for action in becoming abstinent from alcohol. He and the nurse work together to add to a plan of care learning about chronic pain, and what he can do to help alleviate and control symptoms other than the use of opioids and being inactive. The nurse begins to teach him about inactivity exacerbating pain and makes a plan to meet with him to begin using a workbook.

Treatment and Regulatory: The nurse chooses the book Managing Pain before it Manages You (Caudill, 2009) since it specifically discusses alternatives to opioids. The nurse and patient decide that they will read the chapters together in the beginning as the client says he has "enough homework from the chemical dependency counselor". The nurse does add a pain rating scale to the daily assessment to remind herself to assess this on a daily basis. She also discusses the plan of care with other team members.

Case Management: At the time of discharge, 21 days after admission, client has been receiving opioids for pain. He has been practicing some of the relaxation techniques that he has learned from the book but still voices fears that his pain will get out of control. Discharge planning includes a plan for intensive outpatient treatment for substance dependency and an appointment is scheduled with his primary care provider. He is also provided contact information for chronic pain and chemical dependency support groups. Ideally, he will continue to be followed by a case manager who will continue to assess how he is coping with his chronic non-malignant pain and being abstinent from alcohol. He is at high risk to abuse opioids upon discharge and will need case management for discharge planning with continued coordination of care between primary care provider and outpatient addiction treatment program. Outpatient management will include informed consent with treatment agreement, random urine drug testing, and regular documentation of analgesia, activities of daily living, adverse effects and aberrant behaviors.

Significance

Chronic pain and substance abuse are significant health issues that need an active involvement of client and an interdisciplinary approach. Self-care deficit theory provides a guide for nurses and nurse practitioners to advocate for clients with chronic pain and substance dependency. In addition to advocacy, the application of the self care deficit theory of nursing to

CNMP in substance dependency has the potential to reduce risk or relapse from the resulting improvement in pain management.

Summary

Despite developed guidelines of opioid therapy for the treatment of chronic non-malignant pain, chronic non-malignant pain is undertreated. Patients who have a history of or an active substance dependency are even more likely to be undertreated for their pain. Pain and addiction specialists agree that pain and substance dependency need to be treated concurrently but lack of such programs exist. Until more programs exist an option for care is the implementation of the self-care deficit theory of nursing that includes self-management techniques. The self-care deficit theory of nursing enables nursing to implement operations of diagnosis, prescriptive, treatment or regulatory and case management in the area of chronic non-malignant pain management for substance dependency patients. This self-management approach will provide a level of care that would otherwise be unavailable to these patients.

References.

Academy of Pain Medicine, A. P. S., & American Society of Addiction Medicine. (2001) Definitions related to the use of opioids for the treatment of pain. from www.painmed.org

Ackley, B. J. L., G.B. (2011). *Nursing Diagnosis Handbook An Evidence Based Guide to Planning Care*. St. Louis Mosby Elsevier.

Apkarian, A. V., Baliki, N.M., & Geha., P.Y. (2009). Towards a theory of chronic pain. *Progress in Neurobiology, 87*, 81-97.

Association, A. C. P. (2010). Quality of Life Scale. from www.theacpa.org/people/qualityoflife.asp

Brookoff, D. (Ed.). (2008). *The Pathophysiology of Chronic Pain*. Oxford: Oxford University Press.

Carpenito-Moyet, L. J. (2010). *Nursing Diagnosis Application to Clinical Practice* (13th ed.). Philadelphia: Wolters Kluwer.

Chen, F. A., Fishman, S.M., & Kries, P.G. (2008). The Opioid Contract. In H. S. Smith, & Passik, S.D. (Ed.), *Pain and Chemical Dependency* (pp. 359-365). Oxford: Oxford University Press.

Clark, M. R., Stoller, K. B., & Brooner, R. K. (2008). Assessment and management of chronic pain in individuals seeking treatment for opioid dependence disorder. *Can J Psychiatry, 53*(8), 496-508.

Chou, R., Fanciullo, G. J., Fine, P. G., Adler, J. A., Ballantyne, J. C., Davies, P., et al. (2009). Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *J Pain, 10*(2), 113-130.

Compton, P. (2007). The Role of Urine Toxicology in Chronic Opioid Analgesic Therapy *Pain Management Nursing* ,8, pp. 166-172.

Compton, P., & Athanasos, P. (2003). Chronic pain, substance abuse and addiction. *The Nursing Clinics of North America, 38*, 525-537.

Compton, P., Charuvastra, C., Kintaudi, K., & Ling, W. (2008). Should opioid abusers be discharged from opioid-analgesia therapy. *Pain Treatment Topics*. Retrieved from www.Pain-Topics.org Compton, P., Charuvastra, C., Kintaudi, K., & Ling, W. (2000). Pain responses in methadone-maintained opioid abusers. *Journal of Pain and Symptom Management, 20*(4), 237-245.

currentnursing.com. (2009). Retrieved 10/30/2009, from http://currentnursing.com/nursing_theory/self_care_deficit_theory

de Chesnay, M. A., B.A. (Ed.). (2008). *Caring for the Vulnerable Perspectives in Nursing Theory, Practices, and Research* (2nd ed.). Sudbury, MA: Jones and Bartlett.

Diclemente, C. C. (Ed.). (2006). *Natural Change and the Troublesome Use of Substances A Life-Course Perspective*. New York: The Guilford Press.

Doweiko, H. E. (2006). *Concepts of Chemical Dependency* (6 ed.). Belmont, CA: Thomson Higher Education.

DuPen, A., Shen, D., & Ersek, M. (2007). Mechanisms of opioid-induced hyperalgesia. *Pain Management Nursing, 8*, 113-121.

Foundation, T. A. P. (2006). Pain facts overview of American pain surveys [Fact sheet]. from www.painfoundation.org

Geden, E., Isaramalai, S., & Taylor, S. (2001). Self-care deficit theory and the nurse. practitioner's practice in primary care settings. *Nursing Science Quarterly, 14*(1), 29-33.

Gourlay, D. L., & Heit, H.A. (2008). Urine Drug Testing in Pain and Addiction Medicine. In H. S. Smith, & Passik, S.D. (Ed.), *Pain and Chemical Dependency* (pp. 353-358). Oxford: Oxford University Press.

Fleming, M. F., Balousek, S.L., Klessig, C.L., Mundt, M.P., & Brown, D.D. (2007). Substance use disorders in a primary sample receiving daily opioid therapy. *The Journal of Pain, 8*, 573-582.

Hadjistavropoulos, H. D., MacLeod, F.K., & Asmundson, G.J. (1999). Validation of the Chronic Pain Coping Inventory. *Pain, 80*, 471-481.

Hartweg, D. L. (1991). *Dorothea Orem Self-Care Deficit Theory*. Newbury Park, CA: Sage.

Hoffman, J & Froemke, S. (Eds.). (2007). *Addiction Why Can't They Just Stop?* New York: Rodale.

International Association for the Study of Pain. (2003) Pain Clinical Updates, XI, 1-4.

Kirsch, L. K. S., H.S. (2008). Documentation and Potential Documentation Tools in Long-Term Opioid Therapy. In H. S. P. Smith, S.D. (Ed.), *Pain and Chemical Dependency* (pp. 385-391). Oxford: Oxford University Press.

Loeser, J. (2000). The future: will pain be abolished or just pain specialists? *VIIII*(6). Retrieved from www.halcyon.com/iasp

McEwen, M., & Wills, E.M. . (2002). *Theoretical Basis for Nursing*. Philadelphia, PA: Lippincott, Williams and Wilkins.

Miller, W. R., & Carroll, K.M. (2006). *Rethinking Substance Abuse What the Science Shows, and What We Should Do About It*. New York: The Guilford Press.

Miller, W. R., & Rollnic, S. (2002). *Motivational Interviewing: Preparing People for Change* (2nd ed.). New York: The Guilford Press.

Office of Applied Studies, S. A., and Mental Health Services Administration. (2007). The Dasis Report: Facilities offering special treatment programs or groups; 2005. from www.oas.samsha.gov

Orem, D. (1995). *Nursing Concepts of Practice* (5th ed.). St. Louis: Mosby.

Portenoy, R. K. (1999). Pain specialists and addiction medicine unite to address critical issues. *APS Bulletin, 9*(3). Retrieved from www.ampainsoc.org/pub/bulletin/mar99/president.htm Prater, C. D., Zylstra, R.G., & Miller, K.E. (2002). Primary care companion. *Journal Clinical Psychiatry, 4*(Suppl 4), 125-131.

Prochaska, J. O., Norcross, J.C., & Diclemente, C.C. (1994). *Changing for good: A revolutionary six-stage program for overcoming bad habits and moving your life positively forward.* New York: HarperCollins.

Pujol, L. A., Katz, N.P., & Zacharoff, K.L. (2007). *The PainEDU.org Manual A pocket guide to pain management* (3rd ed.). Newton, MA: Inflexxion.

Rosenblatt, A. B., & Mekhail, N.A. (2005). Management of Pain in Addicted/Illicit and Legal Substance Abusing Patients. *Pain Practice, 5*(1), 2-10.

Rosenblum, A., Joseph, H., Fong, C., Kipnis, S., Cleland, C., & Portenoy, R. (2003). Prevalence and characteristics of chronic pain among chemically dependent patients in methadone maintenance and residential treatment facilities. *The Journal of the American Medical Association, 289*(18). Sheu, R., Lussier, D., Rosenblum, A. Fong, C., Portenoy, J., &Joseph. H. et al. (2008). Prevalence and characteristics of chronic pain of patients admitted to an outpatient drug and alcohol treatment program. *Pain Medicine, 9*(7), 911-917.

Smith, G. F. (2001). Pain measurement, the 5th vital sign. *Alabama Nurse, 28*(2).

Tunks, E. R., Crook, J., Weir, R. (2008). Epidemiology of Chronic Pain with Psychological Comormidity: Prevalence, Risk, Course, and Prognosis. *Canadian Journal Psychiatry, 53*(4), 224-234.

Treatment, C. o. S. A. (2004). *Clinical guidelines for the use of buprenorphine in the treatment of opioid addiction*. Rockville, MD: Substance Abuse and Mental Health Service.

Trescot, A., Glaser, S.E., Hansen, H., Benyamin, R., Patel, S., & Manchikanti, L. (2008). Effectiveness of opioids in the treatment of chronic non-cancer pain. *Pain Physician, 11*(Supplement), S181-S200.

Webster, L. R. D., B. (2007). *Avoiding Opioid Abuse While Managing Pain*. North Branch, MN: Sunrise River Press.

Williams, R. M., Hapidou, E.G., Lin, C.A., & Abbasi, H. (2007). Examining the Pain Stages of Change Questionnaire in Chronic Pain. *Physiotherapy Canada, 59*(132-41).

Appendix

A consensus document from the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine.

Definitions Related to the
Use of Opioids for the Treatment of Pain

BACKGROUND

Clear terminology is necessary for effective communication regarding medical issues. Scientists, clinicians, regulators, and the lay public use disparate definitions of terms related to addiction. These disparities contribute to a misunderstanding of the nature of addiction and the risk of addiction, especially in situations in which opioids are used, or are being considered for use, to manage pain. Confusion regarding the treatment of pain results in unnecessary suffering, economic burdens to society, and inappropriate adverse actions against patients and professionals.

Many medications, including opioids, play important roles in the treatment of pain. Opioids, however, often have their utilization limited by concerns regarding misuse, addiction, and possible diversion for non-medical uses.

Many medications used in medical practice produce dependence, and some may lead to addiction in vulnerable individuals. The latter medications appear to stimulate brain reward mechanisms; these include opioids, sedatives, stimulants, anxiolytics, some muscle relaxants, and cannabinoids.

Physical dependence, tolerance, and addiction are discrete and different phenomena that are often confused. Since their clinical implications and management differ markedly, it is important that uniform definitions, based on current scientific and clinical understanding, be established in order to promote better care of patients with pain and other conditions where the use of dependence-producing drugs is appropriate, and to encourage appropriate regulatory policies and enforcement strategies.

RECOMMENDATIONS

The American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine recognize the following definitions and recommend their use.

I. Addiction
Addiction is 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.

II. Physical DependencePhysical dependence is a state of 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.
III. Tolerance
Tolerance is 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.

DISCUSSION

Most specialists in pain medicine and addiction medicine agree that patients treated with prolonged opioid therapy usually do develop physical dependence and sometimes develop tolerance, but do not usually develop addictive disorders. However, the actual risk is not known and probably varies with genetic predisposition, among other factors. Addiction, unlike tolerance and physical dependence, is not a predictable drug effect, but represents an idiosyncratic adverse reaction in biologically and psychosocially vulnerable individuals. Most exposures to drugs that can stimulate the brain's reward center do not produce addiction. Addiction is a primary chronic disease and exposure to drugs is only one of the etiologic factors in its development.

Addiction in the course of opioid therapy of pain can best be assessed after the pain has been brought under adequate control, though this is not always possible. Addiction is recognized by the observation of one or more of its characteristic features: impaired control, craving and compulsive use, and continued use despite negative physical, mental, and/or social consequences. An individual's behaviors that may suggest addiction sometimes are simply a reflection of unrelieved pain or other problems unrelated to addiction. Therefore, good clinical judgment must be used in determining whether the pattern of behaviors signals the presence of addiction or reflects a different issue.

Behaviors suggestive of addiction may include: inability to take medications according to an agreed upon schedule, taking multiple doses together, frequent reports of lost or stolen prescriptions, doctor shopping, isolation from family and friends, and/or use of non-prescribed psychoactive drugs in addition to prescribed medications. Other behaviors which may raise concern are the use of analgesic medications for other than analgesic effects, such as sedation, an increase in energy, a decrease in anxiety, or intoxication; non-compliance with recommended non-opioid treatments or evaluations; insistence on rapid-onset formulations/routes of administration; or reports of no relief whatsoever by any non-opioid treatments.

Adverse consequences of addictive use of medications may include persistent sedation or intoxication due to overuse; increasing functional impairment and other medical complications; psychological manifestations such as irritability, apathy, anxiety, or depression; or adverse legal, economic or social consequences. Common and expected side effects of the medications, such as constipation or sedation due to use of prescribed doses, are not viewed as adverse consequences in this context. It should be emphasized that no single event is diagnostic of addictive disorder. Rather, the diagnosis is made in response to a pattern of behavior that usually becomes obvious over time.

Pseudoaddiction is a term which has been used to describe patient behaviors that may occur when pain is undertreated. Patients with unrelieved pain may become focused on obtaining medications, may "clock watch," and may otherwise seem inappropriately "drug seeking." Even such behaviors as illicit drug use and deception can occur in the patient's efforts to obtain relief. Pseudoaddiction can be distinguished from true addiction in that the behaviors resolve when pain is effectively treated

Physical dependence on and tolerance to prescribed drugs do not constitute sufficient evidence of psychoactive substance use disorder or addiction. They are normal responses that often occur with the persistent use of certain medications. Physical dependence may develop with chronic use of many classes of medications. These include beta blockers, alpha-2 adrenergic agents, corticosteroids, antidepressants, and other medications that are not associated with addictive disorders. When drugs that induce physical dependence are no longer needed, they should be carefully tapered while monitoring clinical symptoms to avoid withdrawal phenomena and such effects as rebound hyperalgesia. Such tapering, or withdrawal, of medication should not be termed detoxification. At times, anxiety and sweating can be seen in patients who are dependent on sedative drugs, such as alcohol or benzodiazepines, and who continue taking these drugs. This is usually an indication of development of tolerance, though the symptoms may be due to a return of the symptoms of an underlying anxiety disorder, due to the development of a new anxiety disorder related to drug use, or due to true withdrawal symptoms.

A patient who is physically dependent on opioids may sometimes continue to use these despite resolution of pain only to avoid withdrawal. Such use does not necessarily reflect addiction.

Tolerance may occur to both the desired and undesired effects of drugs, and may develop at different rates for different effects. For example, in the case of opioids, tolerance usually develops more slowly to analgesia than to respiratory depression, and tolerance to the constipating effects may not occur at all. Tolerance to the analgesic effects of opioids is variable in occurrence but is never absolute; thus, no upper limit to dosage of pure opioid agonists can be established.

Universal agreement on definitions of addiction, physical dependence, and tolerance is critical to the optimization of pain treatment and the management of addictive disorders. While the definitions offered here do not constitute formal diagnostic criteria, it is hoped that they may serve as a basis for the future development of more specific, universally accepted diagnostic guidelines. The definitions and concepts that are offered here have been developed through a consensus process of the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine

This document was prepared by the following committee members: Seddon Savage, MD (Chair) - APS; Edward C. Covington, MD - AAPM; Howard A. Heit, MD - ASAM; John Hunt, MD - AAPM; David Joranson, MSSW - APS; and Sidney H. Schnoll, MD, PhD - ASAM.

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Approved by the APS Board of Directors on February 14, 2001
Approved by the ASAM Board of Directors on February 21, 2001

4700 W. Lake Avenue
Glenview, IL 60025-1485
847/375-4731
Fax 877/734-8751
E-mail aapm@amctec.com
http://www.painmed.org/

4700 W. Lake Avenue
Glenview, IL 60025-1485
847/375-4715
Fax 877/734-8758
E-mail info@ampainsoc.org
http://www.ampainsoc.org/

4601 North Park Avenue
Arcade 101
Chevy Chase, MD 20815
301/656-3920
Fax 301/656-3815
E-mail email@asam.org
http://www.asam.org/

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.

References

American Hospital Association. (1972). Patient's Bill of Rights. Chicago: Author.

American Academy of Pain Medicine (AAPM), American Pain Society (APS), American Society of Addiction Medicine (ASAM). (2001). Definitions related to the use of opioids for the treatment of pain. Glenview, IL: APS.

Breitbart, W. (1993). Suicide risk in cancer and AIDS patients. In C. Chapman, & K. Foley (Eds.), Current and emerging issues
in cancer pain: Research and practice (pp. 319-412). New York: Raven.

Caine, J.M., & Hammes, B.L. (1994). Ethics and pain management: Respecting patient wishes. Journal of Pain and Symptom Management, 9, 160-165.

Compton, P. (1999). Substance abuse. In M. McCaffery, & C. Pasero, Pain: Clinical manual (2nd ed., pp. 428-466). St. Louis:
Mosby.

Dunbar, S.A., & Katz, N.P. (1996). Chronic opioid therapy for nonmalignant pain in patients with a history of substance abuse: Report of 20 cases. Journal of Pain and Symptom Management, 11, 163-171.

Grinstead, S. F., & Gorski, T. T. (1997). Addiction-free pain management. Independence, MO, Herald House/Independence
Press.
Heit, H. (2000). Opioid therapy: Critical issues and new directions. Presented at American Pain Society 19th Annual Scientific Meeting. November 2-5, 2000, Atlanta, GA.
Iocolano, C.F. (2000). Perioperative pain management in the chemically dependent patient. Journal of Perianesthesia Nursing,
15(5), 329-347.

Joint Commission on Accreditation of Healthcare Organizations. (2001). Comprehensive accreditation manual for hospitals: The
official handbook. Oakbrook Terrace, IL: Author. McCaffery M., & Vourakis, C. (1992). Assessment and relief of pain in chemically dependent patients. Orthopedic Nursing, 11(2), 13-27.

Miller, T.R., Lestina, D.C., & Smith, G. S. (2001). Injury risk among medically identified alcohol and drug abusers. Alcoholism:
Clinical and Experimental Research, 25(1), 54-59.

Portenoy, R K., & Payne, R. (1992). Acute and chronic pain. In J.H. Lowinson, P. Ruiz, R.B. Millman, & J.G. Langrod (Eds.), Substance abuse: A comprehensive Textbook (pp. 563-589). Baltimore: Williams & Wilkins.

Robins, L.N., & Regier, D.A. (1991). Psychiatric disorders in America: The epidemiologic catchment area study. The Free Press. New York: The Free Press.

Soderstrom, C.A., Cole, F.J., Jr., & Porter, J.M. (2001). Injury in America: The role of alcohol and other drugs -- An EAST
position paper prepared by the Injury Control and Violence Prevention Committee. Journal of Trauma-Injury Infection &
Critical Care, 50(1), 1-12.

Thompson, M. H. (1996). Ethics committees: Their share in the advocacy role. Seminars in Preoperative Nursing, 5, 62-67.

Tucker, C. (1990). Acute pain and substance abuse in surgical patients. Journal of Neuroscience Nursing, 22, 339-349.

Weissman, D E., & Haddox, J.D. (1989). Opioid pseudoaddiction--An iatrogenic syndrome. Pain, 36, 363-366.

Wesson, D.R., Ling, W., & Smith, D. E. (1993). Prescription of opioids for treatment of pain in patients with addictive disease. Journal of Pain & Symptom Management, 8(5), 289-296.

Suggested Readings

Fleming, M.F., & Barry, K.L. (1992). Addictive Disorders. St. Louis: Mosby.

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).

Sullivan, E.J. (1995). Nursing care of clients with substance abuse. St. Louis: Mosby.Additional Resources for Position Paper

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, McCaffery M. (1999). Pain in the Elderly. In M. McCaffery, & C. Pasero, Pain: Clinical Manual (2nd ed., pp. 674-710). St.
Louis: Mosby.

Therapeutic Plans for Relapse Grinstead, S. F., & T. T. Gorski (1997). Addiction-Free Pain Management. Independence, MO, Herald House/Independence Press. (The entire workbook 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 High-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

American Society for Pain Management Nursing
PO Box 15473 Lenexa, KS 66285-5473
888-342-7766 Fax: 913-599-5340
aspmn@goamp.com
www.aspmn.org