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ASPMN and IntNSA Position Statement on Pain Management and Risks Associated with Substance Use Disorders

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American Society for Pain Management Nursing
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PCSS is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

Addiction Technology Transfer Center	American Society of Addiction Medicine
American Academy of Family Physicians	American Society for Pain Management Nursing
American Academy of Pain Medicine	Association for Multidisciplinary Education and Research in Substance use and Addiction
American Academy of Pediatrics	Council on Social Work Education
American Pharmacists Association	International Nurses Society on Addictions
American College of Emergency Physicians	National Association for Community Health Centers
American Dental Association	National Association of Social Workers
American Medical Association	National Council for Mental Wellbeing
American Osteopathic Academy of Addiction Medicine	The National Judicial College
American Psychiatric Association	Physician Assistant Education Association
American Psychiatric Nurses Association	Society for Academic Emergency Medicine

Target Audience

- The overarching goal of PCSS is to train healthcare professionals in evidence-based practices for the prevention and treatment of opioid use disorders, particularly in prescribing medications, as well for the prevention and treatment of substance use disorders.

Disclosures

- Presenters have no conflicts of interests to report

The content of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.

Educational Objectives

At the conclusion of this activity participants should be able to:

1. Review the position statement as the foundation for formulating appropriate care and assessing for risk of SUD
2. Discuss impact of stigmatization on treatment of pain in persons with SUD
3. Identify available tools to use in an integrated, holistic multidimensional approach to assessment and treatment
4. Summarize practice recommendations clinicians, healthcare systems, and policy makers/legislators

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The Why

- Assessing and managing pain while evaluating risks associated with substance misuse and substance use disorders continues to be a challenge faced by healthcare clinicians.

- Evidence based clinical recommendations are needed in understanding and managing patients with pain and at risk for or with substance use disorders (SUD).

find your why

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Joint Position Statement

- The American Society for Pain Management Nursing (ASPMN) & the International Nurses Society on Addictions (IntNSA) hold the position that:
  - Persons with co-occurring pain and substance use disorder have the right to be treated with dignity and respect and
  - Receive evidence-based, high quality assessment and management for both conditions
  - Using an integrated, holistic, multidimensional approach.

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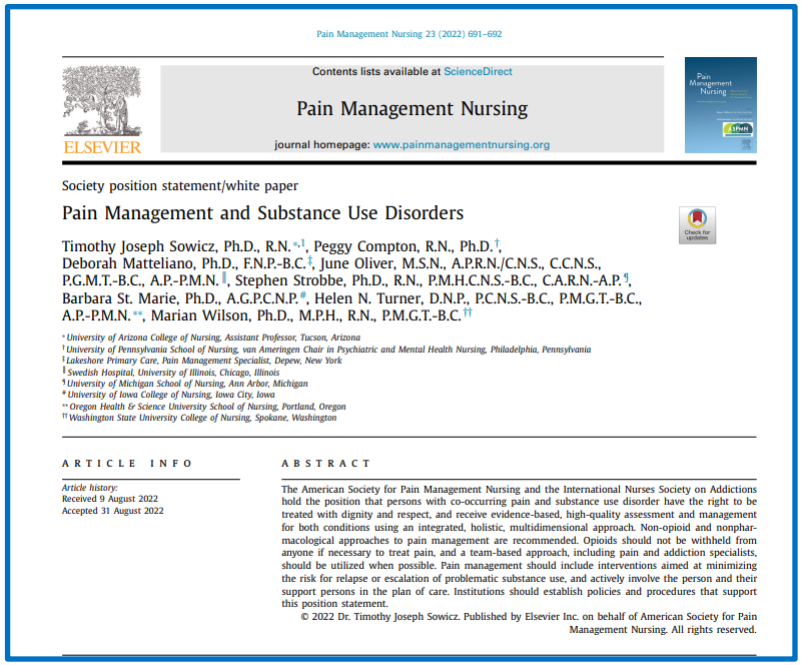
Position Statement Published in *Pain Management Nursing & Journal of Addictions Nursing*



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Pain Management and Substance Use Disorders

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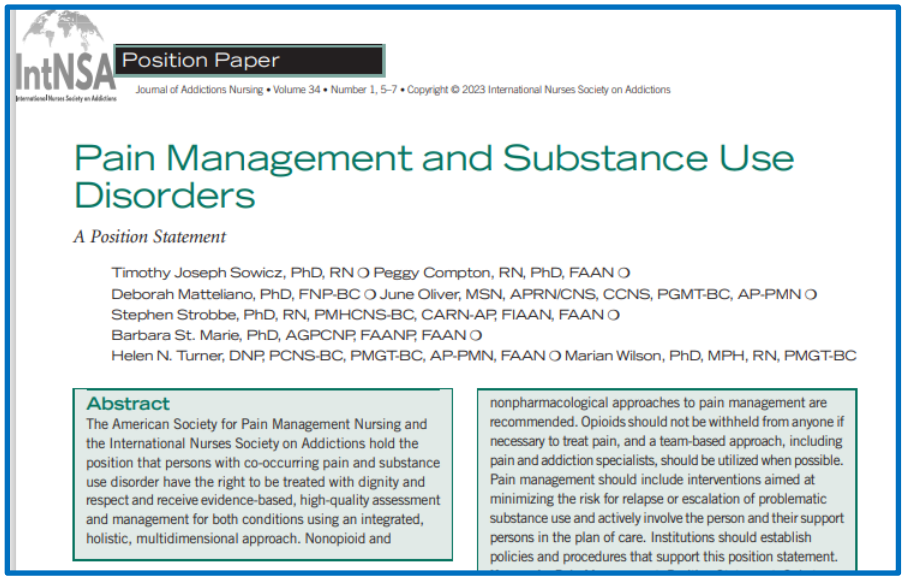
ABSTRACT

The American Society for Pain Management Nursing and the International Nurses Society on Addictions hold the position that persons with co-occurring pain and substance use disorder have the right to be treated with dignity and respect, and receive evidence-based, high-quality assessment and management for both conditions using an integrated, holistic, multidimensional approach. Non-opioid and nonpharmacological approaches to pain management are recommended. Opioids should not be withheld from anyone if necessary to treat pain, and a team-based approach, including pain and addiction specialists, should be utilized when possible. Pain management should include interventions aimed at minimizing the risk for relapse or escalation of problematic substance use, and actively involve the person and their support persons in the plan of care. Institutions should establish policies and procedures that support this position statement.



IntNSA Position Paper

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Pain Management and Substance Use Disorders

A Position Statement

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Abstract

The American Society for Pain Management Nursing and the International Nurses Society on Addictions hold the position that persons with co-occurring pain and substance use disorder have the right to be treated with dignity and respect and receive evidence-based, high-quality assessment and management for both conditions using an integrated, holistic, multidimensional approach. Nonopioid and nonpharmacological approaches to pain management are recommended. Opioids should not be withheld from anyone if necessary to treat pain, and a team-based approach, including pain and addiction specialists, should be utilized when possible. Pain management should include interventions aimed at minimizing the risk for relapse or escalation of problematic substance use and actively involve the person and their support persons in the plan of care. Institutions should establish policies and procedures that support this position statement.

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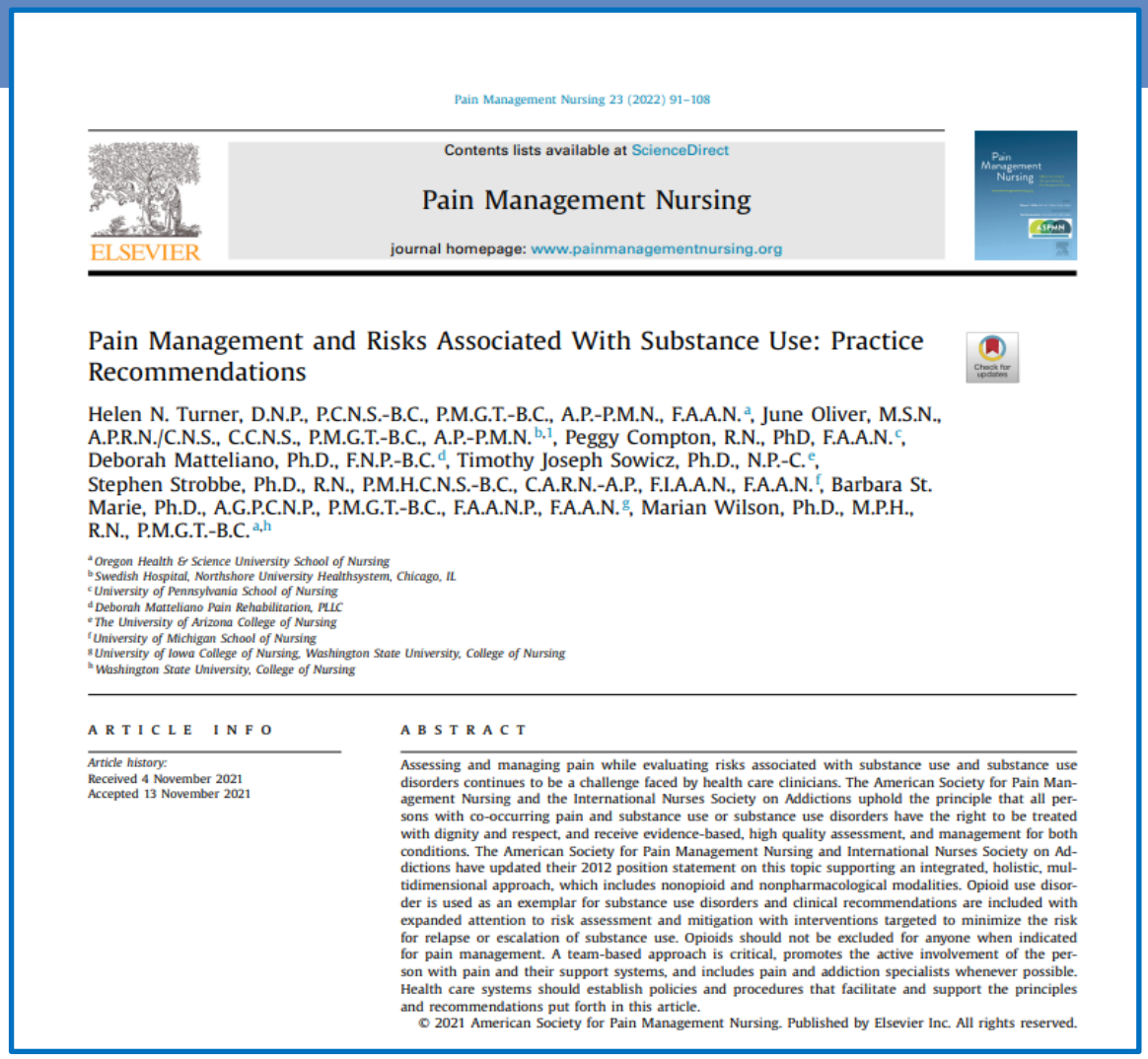

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Pain Management and Risks Associated With Substance Use: Practice Recommendations

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ABSTRACT

Assessing and managing pain while evaluating risks associated with substance use and substance use disorders continues to be a challenge faced by health care clinicians. The American Society for Pain Management Nursing and the International Nurses Society on Addictions uphold the principle that all persons with co-occurring pain and substance use or substance use disorders have the right to be treated with dignity and respect, and receive evidence-based, high quality assessment, and management for both conditions. The American Society for Pain Management Nursing and International Nurses Society on Addictions have updated their 2012 position statement on this topic supporting an integrated, holistic, multidimensional approach, which includes nonopioid and nonpharmacological modalities. Opioid use disorder is used as an exemplar for substance use disorders and clinical recommendations are included with expanded attention to risk assessment and mitigation with interventions targeted to minimize the risk for relapse or escalation of substance use. Opioids should not be excluded for anyone when indicated for pain management. A team-based approach is critical, promotes the active involvement of the person with pain and their support systems, and includes pain and addiction specialists whenever possible. Health care systems should establish policies and procedures that facilitate and support the principles and recommendations put forth in this article.

Turner, H. N. et al. (2022). Pain management and risks associated with substance use: Practice recommendations. *Pain Management Nursing,* 23, 91-108.
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Overview

- Affirm ongoing **TRIPLE crises** of Pain, SUD, overdose deaths
  - Worsening during Covid pandemic
- **Prevalence** of Co-occurring pain & OUD
  - Differentiate OD risks (pain vs SUD vs pain & SUD)
- **Attitudes/regulations** of opioids & SUD
  - Decreased access to care for pain, SUD, & mental health
  - Harms example—rise in suicidality in Veterans
- **Advocate** for balanced understanding of data on opioids/OD
  - Avoid oversimplification of complex issues
  - Acknowledge impact of federal pain guidelines

Impact of Stigma

- Dehumanizes patients with co-occurring SUD & pain
- Reinforces misperceptions & incorrect assumptions
- Interferes with evidence based assessment & management of both diseases
- Lack of full patient disclosure due to fear of judgement
- Hinders therapeutic relationship between patient & provider

Examples from NIDA Words Matter Table—Terms to Avoid, Terms to Use, Why

Instead of…	Use…	Because…
Addict Former Addict	Person with SUD Person in recovery	Shows person "has" a problem rather than "is" a problem
Abuse	For illicit drugs—use For prescribed meds—misuse or other than prescribed	"Abuse" has high association with negative judgements and punishment.
Opioid Substitution Replacement therapy (MAT)	Opioid Agonist Therapy Medication for OUD (MOUD)	MOUD is not a substitution of one addiction for another. It is critical treatment tool aligning with other treatment options.
Clean	Toxicology—testing negative In Remission or recovery Not actively using drugs/substances	Non-stigmatizing and accurate terminology in same way used for other health problems
Addicted Baby	Newborn exposed to substances Baby with signs of withdrawal from prenatal drug exposure Baby with neonatal abstinence syndrome	Babies cannot be born addicted Addiction is a behavioral disorder Non-stigmatizing, accurate terminology as in other illnesses

Recommendations for Holistic Information Gathering

- Goal: Evaluate impact of pain & SUD on person's life/function

- Recognize persistent pain & SUD often co-occur; add to/reinforce each other
  - Patients with pain—65% with anxiety; 83% with depression
  - Patients with SUD—high comorbidity of mood disorders
  - Pain catastrophizing – repetitive negative thought process (not a recognized mood disorder but significant impact)

- Assessment & Screening
  - Screening = asking questions BEFORE S/S evident
  - Assessment = medical/nursing evaluation of symptoms/disease risk

Recommendations for Holistic Information Gathering

1. Pain (not just a number; includes function)
2. Mental, emotional, spiritual health
3. Risk for SUD
   - Definitions/Clarifications
     - Harmful drug use vs misuse vs SUD vs OUD
     - A positive screen for SUD is NOT a diagnosis of SUD (by DSM-V criteria)
4. Monitoring opioid use
   - Opioid misuse = in a manner not prescribed
     - Misuse is not automatically SUD/OUD
     - Most misuse is due to seeking pain relief; responds to education
     - Small % indicate risk of SUD
5. Monitoring for substance withdrawal

Tools for Holistic Information Gathering

- Know what a tool does & does NOT measure
  - Many opioid screening tools look at problematic opioid use behaviors
    - i.e. Current Opioid Misuse Measure (COMM)
  - ONLY ORT-OUD measures OUD risk (as opposed to misuse)
- Many tools available
  - Select instruments as part of your preferred “tool box”

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Table 2 in *Pain Management Nursing* (Turner et al., 2022)

Pain

Mental, emotional, spiritual health

Risk for SUD

Opioid Use

Withdrawal

Diagnosing

Table 2
Instruments and Tools Used for Holistic Information Gathering

Pain
Brief Pain Inventory (Cleeland & Ryan, 1994)
Department of Defense/VA Pain Rating Scale (CVPRS; Buckenmaier, Galloway, Polomano, McDuffie, Kwon, Gallagher, 2013)
Functional Pain Scale (Arnstein, Gentile, Wilson, 2019 [hospitalized populations]; Gloth, Scheve, Stober, Chow, Prosser, 2001 [older adult populations])
McGill Pain Questionnaire (short form; Melzack, 1987)
PROMIS Pain Interference Measure (Amtmann et al., 2010)
Spirituality
Spiritual Well-being Index (Fisher & Ng, 2017)
Anxiety
Generalized Anxiety Disorder Screener (GAD-7) (Spitzer et al., 2006)
Depression
Beck Depression Inventory (primary care version; for children and adolescents; Siu, 2016).
Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1987)
Geriatric Depression Scale (Yesavage et al., 1983)
Hospital Anxiety and Depression Scales (Zigmond & Snaith, 1983)
Patient Health Questionnaire (PHQ)-2 (Löwe et al., 2005)
Patient Health Questionnaire (PHQ)-9 (Kroenke et al., 2001)
PHQ-2 for Adolescents (Richardson et al., 2010)
Suicide
Ask Suicide-Screening Questions (ASQ) Toolkit (National Institute of Mental Health, 2021)
Rocky Mountain Mental Illness Research, Education, and Clinical Center (MIRECC) Therapeutic Risk Management Risk Stratification Table (USDVA, 2021a)
Columbia Suicide Severity Rating Scale (Posner, 2011)
Suicide Assessment Five-Step Evaluation and Triage (SAMHSA, 2009)
Screening for SUD
Alcohol Use Disorders Inventory Test (AUDIT; Bohn et al., 1995)
BRI (Brief Risk Interview; Jones et al., 2014)
CRAFFT 2.1 (adolescent substance use; Knight et al., 1999)
ORT-OUD (Opioid Risk Tool for OUD; Cheatle et al., 2019)
PRO (Prenatal Risk Overview; USPSTF, 2020; Harrison et al., 2012)
SOAPP-R (Screener and Opioid Assessment for Patients with Pain; Butler et al., 2004)
Tools for monitoring opioid use
ABC (Addiction Behaviors Checklist; Wu et al., 2006)
COMM (Current Opioid Misuse Measure; Butler et al., 2007)
PDUQ (Prescription Drug Use Questionnaire; Compton et al., 1998) and self-report version PDUQp (Compton, et al., 2008)
PMQ (Pain Medicine Questionnaire; Adams et al., 2004)
POAC (Prescription Opioid Abuse Checklist; Chabal et al., 1997)
Tool for assessing for substance withdrawal
Adjective Rating Scale for Withdrawal (ARSW; Bickel et al., 1988)
Clinical Institute Withdrawal Assessment for Alcohol-Revised (CIWA-Ar; Sullivan et al., 1989)
Clinical Opioid Withdrawal Scales (COWS; Wesson & Ling, 2003)
Modified Finnegan Neonatal Abstinence Syndrome Tool-Short Form (Maguire et al., 2013)
Withdrawal Assessment Tool-1 (WAT-1; Franck et al., 2008)
Diagnosing substance use disorder (adapted from American Psychiatric Association DSM-5) (American Psychiatric Association, 2013
A problematic pattern of substance use leading to clinically significant impairment or distress, manifested by at least two of the following in a 12-month period:

1. Taken in larger amounts or over a longer period than intended
2. Persistent desire or unsuccessful efforts to but down or control use
3. Great deal of time spent obtaining, using, or recovering from effects
4. Craving, or strong desire or urge to use the substance
5. Recurrent use resulting in failure to fulfill major role obligations
6. Continued use despite related personal or interpersonal problems
7. Important activities given up or reduced because of use
8. Recurrent use in situations in which it is physically hazardous
9. Continued use despite related physiological or psychological problems
10. Tolerance[a]
11. Withdrawal[a]

Severity: Mild (2-3 symptoms); Moderate (4-5 symptoms); Severe (≥6 symptoms).
Early remission: Criteria no longer met ≥3 months and <12 months, except possible craving.
Sustained remission: Criteria no longer met >12 months, except possible craving.

DSM-5 = Diagnostic and Statistical Manual of Mental Disorders; SUD = substance use disorder; USDVA = United States Department of Veterans Affairs; USPSTF = United States Preventive Services Task Force; VA = Veterans Affairs.
[a]These criteria not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

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ORT- OUD Tool

Opioid Risk Tool - OUD (ORT-OUD)

This tool should be administered to patients upon an initial visit prior to beginning or continuing opioid therapy for pain management. A score of 2 or lower indicates low risk for future opioid use disorder; a score of >/= 3 indicates high risk for opioid use disorder.

Mark each box that applies	*YES*	*NO*
Family history of substance abuse		
Alcohol	1	0
Illegal drugs	1	0
Rx drugs	1	0
Personal history of substance abuse		
Alcohol	1	0
Illegal drugs	1	0
Rx drugs	1	0
Age between 16-45 years	1	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	1	0
Depression	1	0
Scoring totals		

- Score 0-2 =
  Low risk future OUD
- Score ≥3 =
  High risk for OUD

Cheatle, M. , Compton, P. A. , Dhingra, L. , Wasser, T. , & O'Brien, C (2019). Development of the revised opioid risk tool to predict opioid use disorder in patients with chronic non-malignant pain. *Journal of Pain, 20* (7), 842–851 .

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Overview of Recommendations

- For ALL patients receiving opioid treatment—12 recommendations
  - Components of treatment plans [Fig 1]
- For patients with acute pain at risk for or with SUD/OUD—3 recommendations
  - Opioid Risk Tool for OUD (ORT-OUD) [Fig 2]
  - Resources for testing & monitoring urine toxicology [Fig 3]
- For patients with persistent pain at risk for SUD/OUD—8 recommendations
  - Medications used to treat OUD in setting of persistent pain [Table 4]
- For patients with acute or persistent pain receiving MOUD—7 recommendations
  - MOUD for those at risk for, or experiencing acute pain episodes [Fig 4]
  - Medications used to treat OUD in the setting of persistent pain [Table 4]
- For tapering opioids—4 recommendations

For ALL Patients Receiving Opioid Therapy

1. Reassure report pain will be addressed
2. Use formal assessment tools/standard procedure to guide individualized care
3. Ensure accurate diagnosis of pain etiology
4. Conduct screening for pain/SUD/Mood Disorders
5. Document a mutually agreed upon Treatment Plan (risks/benefits/boundaries/responsibilities)
6. Maximize multimodal pharm & nonpharm analgesia
7. Continual evaluation of pain/function/AE/opioid use/progress (no changes on pain intensity alone)
8. Individualized adherence monitoring (e.g., pill counts, UDT, PDMPs)
9. Monitor for S/S OUD & other SUDs (keep therapeutic relationship AND refer/treat prn)
10. Consider tapering opioids if continued unsafe behavior/treatment refusal (tapering resources)
11. Document all interactions- use as education/rationale
12. Prescribe naloxone with education

ADDITIONAL Recommendations: Pain & SUD Risk

- **Acute** Pain
  - Short-acting opioids preferred
  - Discharge plan for
    - Monitoring
      - Pain
      - Adherence to treatment/medication
      - Problematic behaviors
      - SUD risk
    - Tapering
      - According to anticipated pain resolution
    - Referral for mental health/SUD recovery support

ADDITIONAL Recommendations: Pain & SUD Risk

- **Persistent** Pain
  - May need higher doses opioids to control pain
  - Slow taper when opioids not needed
  - IF in SUD recovery
    - Assess duration/stability of recovery
    - Identify patient specific triggers for relapse
    - Open communication with patient, SO, nurses/staff with concerns re: Rx
    - Establish relapse plan
      - Do NOT automatically terminate pain care if relapse; intensify recovery efforts/assessments

Pain & Medications for OUD (MOUD)

- Goal: Adequate pain control (INCLUDING opioids) & lower risk of relapse
  - Special notes for buprenorphine, methadone, naltrexone
- For all patients with MOUD—maximize non-opioids & regional anesthesia, use IR opioids, higher doses prn, consult pain/addiction specialists

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MOUD Recommendations: Buprenorphine

- Continue during acute pain
  - Reduce mg doses
  - Maintain mcg doses
- Consider dividing daily dose to q 8 or 12 hour dosing
- Consider rotation to methadone & prn mu-opioid
- If stopped, restart buprenorphine before hospital d/c to prevent relapse; consider full home dosing
- Coordinate with buprenorphine prescriber if mu-opioid needed post d/c

MOUD Recommendations: Methadone

- Daily dose does not provide analgesia
- Verify dose (if unable, not more than 40mg daily recommended)
- Continue verified dose during hospitalization
  - IV methadone if NPO; hold only if medical instability
  - Consider dividing daily dose to q4 or q8h dosing
  - Consider continuous iv infusion
  - Consider extra methadone doses if benefits outweigh risks
- Communicate with methadone program if dose changed OR if additional mu-opioids planned post d/c

MOUD Recommendations: Naltrexone

- D/C 72 hours prior to surgery
- D/C monthly depot injection 1 month prior to surgery
- For acute event:
  - Opioid 10-20x the usual dose may overcome naltrexone blockade
  - Hazardous as naltrexone dissociates – may cause receptor super-sensitivity
  - Close monitoring; naloxone available
- Avoid hepatoxic medications (e.g., acetaminophen) & monitor LFTs
- Consult with MOUD prescriber for restart of naltrexone or alternative if mu-opioids continue

Recommendations for Tapering Opioids

- Why/when?
  - Safety concerns, uncontrolled side effects, concurrent medications that raise OD risk, no improvement in pain/function OR worsening mental health
- Considerations prior to taper
  - Taper speed, withdrawal symptom management, interdisciplinary care availability
- Taper plan
  - Maximize multimodal
  - Monitor physical/mental/spiritual symptoms
  - Monitor patient support systems
- Taper duration
  - Little research, wide variations from days to years
- Appendix with tapering resources
  - Opioid Taper Decision Tool- USDVA 2016
  - Clinician Guide on Dose Reduction- USHHS 2019

Recommendations to Optimize Care: Co-occurring Pain & SUD

- For ALL clinicians—11 recommendations
  - Self-appraisal of knowledge deficits
  - Advocate for best practice/policies
  - Stay informed of current knowledge pain/SUD; attend conferences/read journals
  - Become certified in Pain Management & Addictions through professional organizations (ASPMN, IntSNA)
  - APRNs consider prescribing buprenorphine for OUD (X waiver not required)
  - Role model non-stigmatizing language & behaviors
  - Seek support/expert consultation as needed (i.e., understand opioid tolerance)
  - Support patient education & shared decision making with patients
  - Participate in research/projects improving care for pain/SUD
  - Differentiate use of buprenorphine & methadone for pain vs SUD

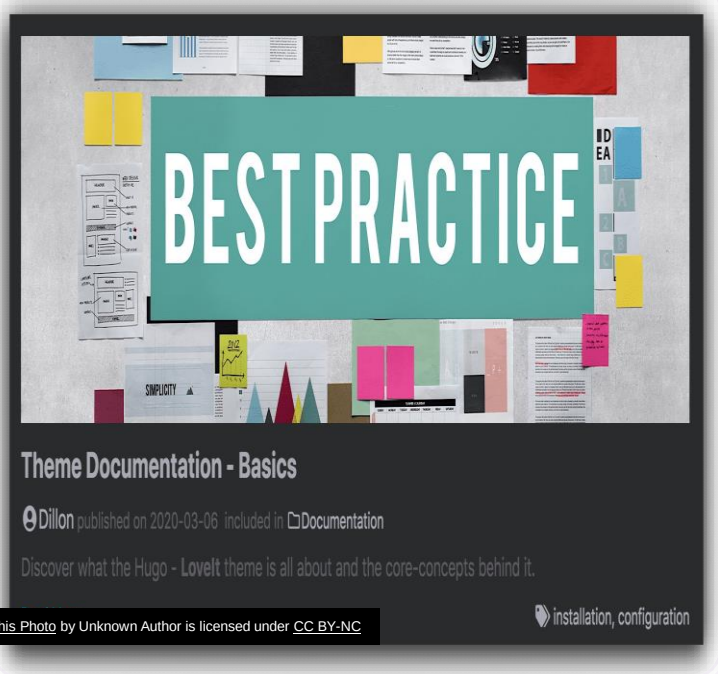
Recommendations to Optimize Care: Co-occurring Pain & SUD

- For healthcare systems—6 recommendations
  - Engage stakeholders in policy making (include patients)
  - Convene clinical practice committees- educate & support clinicians
  - Utilize pharmacists for optimal medication access
  - Ensure ongoing quality review/improvement re: care of patients with pain/SUD
  - Promote nurse-driven research & translation into care
  - Ensure institutional opioid stewardship to balance of pain/safety

Recommendations to Optimize Care: Co-occurring Pain & SUD

- For policy makers/legislators—4 recommendations
  - Equal education all prescribers of MOUD
  - Support MOUD prescribing options for all APPs (APRNs & PAs)
  - Equitable reimbursement for evidence-based non-pharm modalities
  - EBC/regulation same for SUD clinicians/centers as for all healthcare settings.

Summary



"…persons with co-occurring pain and substance use disorder have the right to be treated with dignity and respect, and receive evidence-based, high quality assessment and management for both conditions using an integrated, holistic, multidimensional approach."

- The position statements & manuscript are resources for clinical guidance & collaborative discussions with patients & co-workers.

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PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid use disorder.
- PCSS Mentors are a national network of providers with expertise in **addictions, pain, evidence-based treatment including medications for opioid use disorder (MOUD)**.
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

For more information visit:

https://pcssNOW.org/mentoring/

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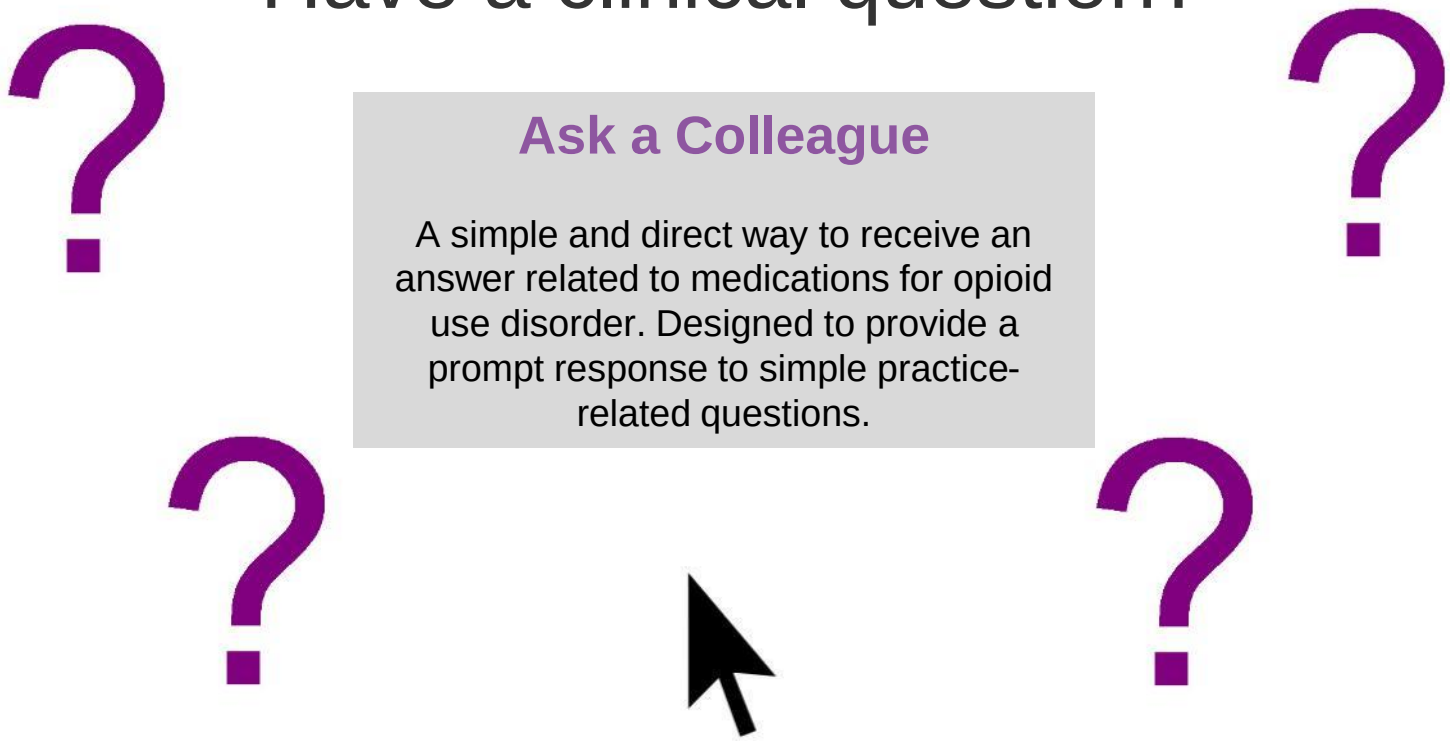

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A simple and direct way to receive an answer related to medications for opioid use disorder. Designed to provide a prompt response to simple practice-related questions.

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