

BASED ON TIP 54

# Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders

## QUICK GUIDE FOR CLINICIANS



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Based on TIP 54

# Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders

## QUICK GUIDE FOR CLINICIANS

This Quick Guide is based entirely on information contained in TIP 54, published in 2012. No additional research has been conducted to update this topic since publication of TIP 54.

## Why a Quick Guide?

This Quick Guide provides succinct, easily accessible information to clinicians about the use of medications to help patients with substance use disorders (SUDs) deal with chronic noncancer pain (CNCP). The guide is based entirely on *Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders*, Number 54 in the Treatment Improvement Protocol (TIP) series.

Users of the Quick Guide are invited to consult the primary source, TIP 54, for more information and a complete list of resources for pain management among people with SUDs. To order a copy of TIP 54 or to access it online, see the inside back cover of this guide.

### DISCLAIMER

The opinions expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of the Substance Abuse and Mental Health Services Administration (SAMHSA) or the U.S. Department of Health and Human Services (HHS). No official support of or endorsement by SAMHSA or HHS for these opinions or for the instruments or resources described is intended or should be inferred. The guidelines presented should not be considered substitutes for individualized client care and treatment decisions.

## What Is a TIP?

The TIP series provides professionals in behavioral health and related fields with consensus-based, field-reviewed guidelines on behavioral health treatment topics of vital current interest. TIPs have been published by SAMHSA since 1991.

TIP 54, *Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders*:

- Presents clinical guidelines for the management of CNCP experienced by patients with SUDs.
- Provides an overview of the dynamics of pain management and substance abuse, focusing on how one affects the treatment of the other.
- Offers considerations for treating a patient who is in recovery from an SUD, or is actively using addictive substances, including guidance on use of opioids in treating pain.
- Provides information on how to work most effectively with the patient to achieve the best possible outcome in treating both chronic pain and addiction.

## Introduction

CNCP is common throughout the general population as well as among those with an SUD.

### Statistics on Substance Use and Chronic Pain in the United States

Category	%
Chronic pain patients who may have addictive disorders	32
People ages 20 and older who report pain that lasted more than 3 months	56
People experiencing disabling pain in the previous year	36
People ages 65 and older who experience pain that has lasted more than 12 months	57
Civilian, noninstitutionalized U.S. residents ages 12 and older who report nonmedical use* of pain relievers in past year	5
People ages 12 and older who report that they initiated illegal drug use with pain relievers	19
People with opioid addiction who report chronic pain	29–60

See TIP 54, page 1, for sources.

\* *Nonmedical use is use for purposes other than that for which the medication was prescribed.*

## **Definitions**

**addiction.** A primary, chronic, neurobiologic disease characterized by impaired *control* over drug use or compulsive use, *continued* use despite harm, and *craving* (clinicians commonly refer to these behaviors as the “3Cs”).

**addictive substance.** In this TIP, drugs or medications that elicit “drug seeking” behaviors are referred to as *addictive*.

**behavioral health.** Substance use issues, mental health issues, and the prevention of both.

**chronic noncancer pain (CNCP).** Pain that is unassociated with an imminently terminal condition and requiring long-term management.

**chronic pain syndrome.** Intractable pain of 6 months or longer, with marked alteration of behavior; depression or anxiety; marked restriction in daily activities; frequent use of medication and medical services; no clear relationship to organic disorder; and a history of multiple, nonproductive tests, treatments, and surgeries.

**hyperalgesia.** An abnormally intense response to a normally noxious stimulus.

**narcotic.** Substance used to induce narcosis or stupor. (*Narcotic* is not a synonym for the opioid class of medications.)

**opioid-induced hyperalgesia.** Hyperalgesia that results from the effects of opioids on the central nervous system (CNS).

**pain.** An unpleasant sensory or emotional experience that is associated with actual or potential tissue damage; it is subjective and may not always be corroborated by objective data.

**physical dependence.** A state of adaptation manifested by a drug-class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, a decrease in the level of the drug in the blood, or administration of an antagonist.

**pseudoaddiction.** Aberrant drug-related behaviors that resemble those of patients with addiction but that actually result from inadequate treatment of pain.

**recovery.** A process of change through which the individual with an SUD achieves abstinence, wellness, and improved health and quality of life.

**relapse.** A return to substance use after a period of abstinence.



**substance use disorder (SUD).** A condition that includes alcohol and drug problems.

**tolerance.** A state of adaptation in which exposure to a substance induces changes that result in a diminution of one or more of the substance's effects over time.

*For more detailed definitions, see TIP 54, Chapter 1.*

### ***Pain and Addiction***

CNCP and addiction frequently co-occur. They have shared neurophysiological patterns, and most pain and SUDs involve abnormal neural processing. They are not static conditions:

- Both fluctuate in intensity over time and under different circumstances.
- Both require ongoing management.
- Treatment of one condition can support or conflict with treatment for the other.
- A medication appropriately prescribed for a particular chronic pain condition may be inappropriate, given the patient's SUD history.

Both conditions:

- Are neurobiological, with evidence of disordered CNS function.
- Are mediated by genetics and environment.

- May have significant behavioral components.
- May have serious harmful consequences if untreated.
- Often require multifaceted treatment.
- Have similar physical, social, emotional, and economic effects on health and well-being.

Effective CNCP management in patients with or in recovery from SUDs must address both conditions simultaneously.

### ***Chronic Pain***

Chronic pain often results from a process of neural sensitization following injury or illness in which:

- Thresholds are lowered.
- Responses are amplified (hyperalgesia).
- Normally non-noxious stimulation becomes painful (allodynia).
- Spontaneous neural discharges occur.

### ***Pain's Effect on Health***

- Contributes to a sense of exhaustion.
- Can trigger emotional responses (e.g., sleeplessness, anxiety, depressive symptoms).
- Emotional responses can in turn produce more pain.
- Physiological and psychological sequelae of CNCP can be exacerbated by such factors as inactivity and overuse of sedating drugs.

## ***Risk Factors for Addiction***

- Genetics—Forty to sixty percent of a person's vulnerability to addiction may be genetic.
- Mental illness—A person may attempt to relieve depression or anxiety with substances.
- Environmental factors—Examples include poverty, poor parental support, living in a community with high drug availability, and using substances at an early age.

## ***Cross-Addiction***

Addiction to one substance can be linked with addiction to other substances. Individuals with chronic pain and histories of SUDs may be at increased risk of cross-addiction to any medication that acts on the brain as a reinforcing agent.

## ***Cycle of Chronic Pain and Addiction***

CNCP provides both positive and negative reinforcement of substance use:

- Positive reinforcement—A behavior is followed by a consequence that is desirable (e.g., euphoria from heroin use).
- Negative reinforcement—A behavior is followed by the elimination of a negative consequence (e.g., pain reduction from heroin use).

If the drug produces physical dependence, the person may have not only increased pain when the substance is absent, but also withdrawal symptoms (e.g., anxiety, nausea, cramps, insomnia). Withdrawal symptoms may lead to an increase in symptoms of depression and an increase in the potential risk for suicide. All these symptoms are relieved by ingesting more of the drug that caused the dependence. A similar situation may occur if the drug is one that elicits rebound symptoms. For example, ergot relieves migraine, but excessive use leads to rebound headaches that are more persistent and treatment resistant than were the original headaches.

An illusion of benefit produced by reinforcing drugs can create a paradoxical situation in which long-term use of the substance creates the very symptoms the person hopes to alleviate. People commonly drink to relax or “cheer up,” yet chronic alcohol abuse leads to depression and anxiety.

*For more detailed information, see TIP 54, Chapter 1.*

## Patient Assessment

Assessment must include more than measures of pain intensity. Obtain collateral information from families, pharmacists, and other clinicians. If the patient declines to give full consent for these discussions, prolonged treatment with controlled substances may be contraindicated.

### **Assessment Tools**

- Provide supplemental information for treatment planning and assessment of risk and outcomes.
- Can reduce clinician bias during patient assessment.

The sensitivity and specificity of screening instruments vary, and all can yield false-positive or false-negative results. In addition, no single instrument has been shown to be appropriate for use with all patient populations. Because of their limitations, standardized tools should not be the absolute determinants of treatments offered or withheld.

Tools assess for:

- Pain level.
- Dimensions of pain.
- Pain interference and functional disorder.
- Substance use disorder (SUDs).

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- Emotional distress, anxiety, pain-related fear, and depression.
- Coping.

*For a list of assessment tools, see TIP 54, Appendix B.*

### **Assessing Pain and Function**

Assessment of CNCP should include documentation of the following:

- Pain onset, quality, and severity; mitigating and exacerbating factors; and the results of investigations into etiology
- Pain-related functional impairment
- Emotional changes (e.g., anxiety, depression, anger) and sleep disturbances
- Cognitive changes (e.g., attentional capacity, memory)
- Family response to pain (i.e., supportive, enabling, rejecting)
- Environmental consequences (e.g., disability income, loss of desired activities, absence from desirable or feared work)
- Physical examination
- Partial mental status examination (e.g., affect [how pain is experienced], somatic preoccupation, cognition, moans, gasps, lying down during the interview)

Consider factors that may complicate an assessment:

- Individuals with similar conditions may describe and rate their pain differently.
- Functional impairments affect patients differently.
- Pain scores do not reflect tissue pathology, disability, or treatment response.
- Pain reduction is insufficient to judge treatment success, which also requires optimization of function and normalization of mood.

### ***Assessing Substance Use and Addiction***

Patient self-reports of substance use, whether via interviews or structured self-report questionnaires, should be corroborated by other sources of information (e.g., medical records, interviews with family, urine toxicology, information from State prescription monitoring programs).

Questions about nicotine and caffeine use provide opportunities to move to assessment of other substances, beginning with alcohol, the most commonly abused substance. A good prescreening question is, “When did you last have a drink of beer, wine, or liquor?”

If the patient reports drinking within the last year, followup questions should address:

- Frequency.
- Quantity.
- Evidence of binge drinking.

Whether or not the patient reports drinking, probe for the use of licit and illicit drugs, starting with the most commonly used illicit drug in the United States, marijuana. Questions can continue to address other major classes of drugs with abuse potential (e.g., depressants, stimulants, opioids), with particular attention to use related to controlling pain or the patient's anxiety and fear of pain.

### ***Screening for Substance Use Disorders***

Although the amount of substance used is significant, it is more important to evaluate the consequences of the drug and alcohol use on life domains, such as family, work or school, and involvement in the criminal justice system. When use interferes with normal function, addiction is likely. Furthermore, addiction is characterized by impaired ability to control use of the substance.

*For the criteria for substance abuse and substance dependence from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSMIV-TR), see TIP 54, Chapter 2, Exhibit 2-6.*



## Steps Following Substance Abuse Assessment

If	Then
Abuse is remote and patient is in long-term recovery	Verify and support recovery efforts
Patient is on buprenorphine or methadone maintenance therapy (MMT)	Verify and continue buprenorphine or MMT
Abuse appears active	Refer patient to substance abuse specialist for further evaluation

Adapted from Passik, S. D., & Kirsch, K. L. (2004). Opioid therapy in patients with a history of substance abuse. *CNS Drugs*, 18(1), 13–25.

*For a list of SUD screening tools, see TIP 54, Appendix B, Exhibit B-4.*

### Referring for Further Assessment

If the clinical interview, collateral interview, medical records, and screening suggest an unacknowledged SUD in a patient seeking treatment for CNCP, then:

- Refer the patient to an SUD specialist, if possible.
- Present the referral using a matter-of-fact and unapologetic tone.
- Avoid getting distracted by the patient's explanation of his or her substance use.

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- Assure the patient that referral does not mean transfer of care.
- Help the patient make the appointment or make the appointment for the patient.

*For a sample consent form, see TIP 54, Appendix C.*

### **Psychiatric Comorbidities**

Both CNCP and SUDs are associated with high rates of psychiatric comorbidities, which can be preexisting or which can develop or worsen with chronic pain or SUDs. Presence of comorbid psychiatric conditions should be assessed regularly in every patient with CNCP. Where indicated, refer patients to a mental health provider. Commonly associated psychiatric conditions include the following:

- Anxiety
- Depression
- Post-traumatic Stress Disorder
- Somatization
- Suicide

### **Assessing Ability To Cope With Chronic Pain**

The concept of acceptance refers to the patient's belief that:

- There is more to life than pain.

- Being completely free of pain is unrealistic.
- Activities should be pursued, even at the price of some increase in pain.

Compared with patients who have not accepted pain, patients who have high levels of acceptance report:

- Lower pain intensity.
- Less pain-related anxiety and avoidance.
- Less depression.
- Less physical and psychosocial disability.
- More daily uptime.
- Better work status.

*For a list of tools to assess coping, see TIP 54, Chapter 2, Exhibit 2-12.*

## **Evaluating Risk of Developing Problematic Opioid Use**

When any patient with a behavioral health disorder is considered for opioid therapy for CNCP, carefully weigh the risks and benefits of opioid use. Risk assessment is made over time and course of treatment. Levels of risk depend on the patient characteristics:

- Low (e.g., no history of substance abuse; minimal, if any, risk factors)
- Medium (e.g., history of non-opioid SUD, family history of substance abuse)

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- High (e.g., active SUD, history of prescription opioid abuse)

*Complete copies of the following tools are found in TIP 54, Chapter 2:*

- Screener and Opioid Assessment for Patients with Pain—Revised (SOAPP-R) (Exhibit 2-14)
- Opioid Risk Tool (ORT) (Exhibit 2-15)

### **Ongoing Assessment**

Assess all patients who have CNCP at regular intervals, because a variety of factors can alter treatment needs, such as:

- Development of tolerance to a particular opioid.
- The underlying disease condition may change another physical or mental health problem.
- Changes in the patient's cognitive functioning.

*For more detailed information, see TIP 54, Chapter 2.*

## Chronic Pain Management

Discuss with the patient treatment goals that include:

- Reducing pain.
- Maximizing function.
- Improving quality of life.

The best outcomes can be achieved when chronic pain management:

- Addresses co-occurring mental disorders.
- Incorporates suitable nonpharmacologic and complementary therapies for symptom management.

The effectiveness of multiple interventions is augmented when all medical and behavioral healthcare professionals collaborate on a team. This requires:

- Identification of a designated lead care coordinator.
- A good system of communication among team members and the patient.

As part of this team, addiction specialists can:

- Put safeguards in place to help patients take opioids appropriately.
- Reinforce behavioral and self-care components of pain management.

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- Work with patients to reduce stress.
- Assess patients' recovery support systems.
- Identify relapse.

### ***Treating Patients in Recovery***

- Treat CNCP with non-opioid analgesics as determined by pathophysiology.
- Recommend or prescribe nonpharmacological therapies.
- Treat comorbidities.
- Assess treatment outcomes.
- Initiate opioid therapy only if the potential benefits outweigh risk and only for as long as it is unequivocally beneficial to the patient.

Non-opioid analgesics include:

- Acetaminophen.
- Nonsteroidal anti-inflammatory drugs (NSAIDs).
- Adjuvant medications originally developed for other purposes but have analgesic properties for certain conditions.

Benzodiazepines are not recommended for the treatment of CNCP in patients who have a comorbid SUD, beyond very short-term, closely supervised treatment of acute anxiety states. Smoked marijuana is not recommended for treating CNCP.

## ***Nonpharmacological Treatments***

- Pose no risk of relapse.
- May be more consistent with the recovering patient's values and preferences than pharmacological treatments, especially opioid interventions.
- May reduce pain and improve quality of life in some patients who have CNCP.
- Should be included in most pain treatment plans.

### Therapeutic exercise:

- Can increase strength, aerobic capacity, balance, and flexibility.
- Can improve posture and enhance general well-being.
- Can be an antidote to feelings of helplessness and personal fragility.
- May alleviate several pain conditions (e.g., back pain, neck pain, fibromyalgia).
- Reduces anxiety and depression.
- May benefit individuals undergoing SUD treatment.

### Physical therapy (PT):

- Can help patients increase range of motion, strength, and functioning.
- Many widely used interventions lack definitive evidence.

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- Encourages patients' involvement in their own recovery.

#### Cognitive-behavioral therapy:

- Can reduce pain and associated distress.
- Has been shown to have a small but significant benefit in treating SUDs.

#### Complementary and alternative medicine:

- Twenty-seven to sixty percent of chronic pain patients use such treatments.
- They hold therapeutic promise, but may interact with conventional treatments.
- Manual therapies are the most widely used and most studied.
- Chiropractic and massage therapies are often covered by health insurance.

### ***Treating Psychiatric Comorbidities***

Research shows well-established associations among chronic pain, SUDs, and mental disorders. Therefore, management of patients with CNCP must include intervention for co-occurring psychopathology.

Benzodiazepines are generally indicated for short-term treatment of anxiety; however, anxiety associated with



chronic pain commonly persists for years. Effective options include:

- Psychological and behavioral treatments.
- Selective serotonin reuptake inhibitors (SSRIs).
- Serotonin–norepinephrine reuptake inhibitors (SNRIs).
- Tricyclic antidepressants.
- Several anticonvulsants.

To treat the person who somatizes extensively:

- Complete an inventory of all the patient's complaints.
- Emphasize history and physical examination in the evaluation.
- Validate the patient's symptoms while assuring him or her about the absence of worrisome pathology.
- Minimize expensive or invasive tests and treatments.
- Minimize use of medications with abuse liability, especially short-acting medications used as needed (PRN).
- Minimize use of passive modalities of therapy.
- Schedule regular appointments rather than PRN visits.
- Adequately treat comorbid Axis 1 (i.e., major psychiatric) disorders.
- Refer patients for counseling or relaxation training, as available.

## ***Opioid Therapy***

Limitations include:

- Diminished efficacy over time.
- Adverse effects that many patients cannot tolerate.
- Risk of addiction or addiction relapse.
- Opioid-induced hyperalgesia.
- Many potential alcohol or drug interactions.
- When an SUD co-occurs with CNCP, benefits are not well-established and risk of relapse is increased.

Opioid selection:

- Select opioids with minimal rewarding properties (e.g., tramadol, codeine), when effective.
- Avoid prescribing suprathreshold doses.
- If higher-potency opioids are required, prescribe slow-onset opioids with prolonged duration of action.
- The practice of using short-acting medications preemptively before pursuing activities known to cause pain is controversial for patients with CNCP and is especially hazardous for people with current or past SUDs.
- The route of administration may influence addiction risk; some clinicians favor transdermal medication.

### Methadone Titration

The titration of methadone for chronic pain is complex and potentially dangerous because methadone levels increase during the first few days of treatment. This risk is compounded by the variable half-life among individuals and the large number of drug interactions. In addition, cardiac toxicity (e.g., QT prolongation, torsade de pointes) is possible. The majority of deaths secondary to methadone occur in the first 14 days of use because:

- The initial dose is too high.
- It is titrated too quickly.
- It interacts with other drugs or medications.

Sources:

- Chou, R., Fanciullo, G. J., Fine, P. G., Adler, J. A., Ballantyne, J. C., Davies, P., et al., for the American Pain Society–American Academy of Pain Medicine Opioids Guidelines Panel. (2009). Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *Journal of Pain*, 10(2), 113–130.
- Weschules, D. J., Baib, K. T., & Richeimer, S. (2008). Actual and potential drug interactions associated with methadone. *Pain Medicine*, 9(30), 315–344.

Dose finding:

- Dose finding can be complicated because of existing or rapidly developing tolerance to opioids and because analgesics affect individuals differently.
- If low doses of opioids (other than methadone) are initiated for severe pain, they should be titrated

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rapidly to avoid subjecting the patient to a prolonged period of dose finding.

- If relatively high doses are initiated, titration should be slower and determined to a great extent by the half-life of the drug.
- Dose finding for methadone can be dangerous.
- When an effective dose has been determined, total opioid dose should thereafter be escalated very slowly, if at all, as tolerance develops.

#### Relapse:

- For patients on chronic opioid therapy who have minor relapses and quickly regain stability, provision of substance abuse counseling may suffice.
- Establish relationships with substance abuse treatment specialists who are willing to provide services for patients who need additional support in their recovery but do not require extensive services.
- For relapse in patients for whom opioid addiction is a serious problem, referral to an opioid treatment program for MMT may be the best choice; or, replacement of full agonist opioids with the partial opioid agonist buprenorphine.

Opioids should be discontinued if patient harm and public safety outweigh the benefit. This situation may be apparent either early in therapy or after a long period of successful treatment.

## ***Treating Patients in Medication-Assisted Recovery***

As with other patients:

- Start with recommending or prescribing nonpharmacological and non-opioid therapies.
- Treat comorbidities.
- Closely monitor treatment outcomes for evidence of benefit and harm.

The schedule and doses of opioid agonists sufficient to block withdrawal and craving are unlikely to provide adequate analgesia. Because of tolerance, a higher-than-usual dose of opioids (in addition to the maintenance dose) may be needed to provide relief.

### **Buprenorphine**

- Is an effective analgesic.
- Should be given three times a day when pain reduction is a goal.
- In high doses, tends to reduce the reinforcing effects of inappropriately consumed opioids.
- In high doses, may reduce the effectiveness of opioids given for additional analgesia in the case of trauma or acute illness.
- Displaces full agonists and can induce acute opioid withdrawal.

## **Methadone**

- Adequate pain relief is not obtained through a single daily dose because the analgesic effects (approximately 6 hours) are short-acting in comparison with the half-life (variable, up to 36 hours in some patients).
- Finding a safe dose is difficult; pain patients may take 10 days or longer to stabilize, so titrate very slowly and balance the risk of insufficient dosing with the life-threatening dangers of overdosing.
- Advise patients to stop methadone treatment if they become sedated.

Methadone is an especially desirable analgesic for chronic use because of its low cost and its relatively slow development of analgesic tolerance; however, it is also especially toxic because of issues of accumulation, drug interaction, and QT prolongation. For these reasons, it should be prescribed only by providers who are thoroughly familiar with it.

## **Naltrexone**

- Patients taking naltrexone should not be prescribed outpatient opioids for any reason.
- Naltrexone blocks the effect of opioids.
- Increasing the dose to overcome the blockade effect of naltrexone puts the patient at risk for respiratory arrest.

## ***Tolerance and Hyperalgesia***

- Tolerance—decreased sensitivity to opioids.
- Opioid-induced hyperalgesia (OIH)—increased sensitivity to pain resulting from opioid use.

In a clinical setting, it may be impossible to distinguish between the two conditions, and they may coexist. When patients develop tolerance to the analgesic effects of a particular opioid, either dose escalation or opioid rotation (switching from one to another) may be useful.

If a patient requests an increase in opioid dose, try to discern whether the patient is experiencing increased pain or analgesic tolerance or is seeking some other effect (e.g., sedation, reduced anxiety). When nonanalgesic effects seem to be the basis for the request, alternative non-opioid medications should be provided and opioid doses should not be increased.

Treating pain with a multimodal approach—in addition to analgesics—may reduce the need for opioids, thereby decreasing the risk of tolerance and OIH.

## ***Treating Pain in Patients Who Have Active Addiction***

The presence of active addiction—whether to alcohol, opioids, or other substances—makes successful treatment of chronic pain improbable. It may also be impossible for clinicians in the primary care setting to provide the comprehensive services necessary to treat both conditions. Refer patients with an active SUD for formal addiction treatment and work closely with that provider. Patients who do not consent to addiction treatment should not be prescribed scheduled medications, except for acute pain or detoxification.

### ***Acute Pain Episodes***

- Patients in recovery may benefit from nonpharmacological pain control.
- Patients in recovery may benefit from being switched from short- to long-acting medications as quickly as appropriate.
- Patients on agonist therapy for addiction or pain may be continued on their current opioid or on an equivalent dose of an alternative opioid; however, this should not be expected to control acute pain, which requires supplementation with (often greater-than-usual doses of) additional opioids. Adjuvant NSAIDs may provide pain relief with a reduction in opioid usage.



- Patients on buprenorphine for opioid addiction may have reduced benefit from full agonist opioids used for acute pain. Non-opioid analgesics can be used; in some cases buprenorphine will need to be discontinued so that full agonist opioids for pain can be used.
- Patient-controlled analgesia should have relatively high bolus doses and short lockout intervals; such patients should be closely monitored by medical staff.
- Patients who are dependent on opioids or sedatives (including benzodiazepines) should not be withdrawn from these medications while undergoing acute medical interventions.

### ***Treating Patients Who Have HIV/AIDS***

A vast range of pain syndromes are common in patients who have HIV/AIDS. A large number of patients have a comorbid SUD, which complicates the use of opioid analgesics.

Core principles of treating CNCP in these patients include:

- Meticulous diagnosis of the pain mechanism and etiology.
- Monitoring for benefits and adverse effects of treatment.

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- Use of the World Health Organization's pain ladder (see <http://www.who.int/cancer/palliative/painladder/en/index.html>) for titrating analgesics.
- Addressing the psychological aspects of the illness, as well as functional restoration.
- Incorporating nonpharmacological therapies (e.g., PT modalities, acupuncture, biofeedback training, hypnosis) that may be helpful.

*For more detailed information, see TIP 54, Chapter 3.*

## Managing Addiction Risk in Patients Treated With Opioids

Adopt a universal precautions approach toward patients who have CNCP. In the context of pain treatment, a universal precautions approach refers to a minimum standard of care applied to all patients who have CNCP, whatever their assessed risk.

Help patients adhere to treatment plans by:

- Employing treatment agreements.
- Regulating visit intervals.
- Controlling medication supply.
- Conducting urine drug testing (UDT).
- Including the patient's support network in monitoring efforts.

## ***Urine Drug Testing***

UDT is subject to both false-positive and false-negative results. Interpret results carefully and explore the possible causes of unexpected findings before taking action. For example, prescribed medication may not show up in a UDT result because:

- The patient did not use medications or did not use them recently.
- The patient excretes medications or metabolites at a rate different from normal.
- The test was not sufficiently sensitive to detect the medications at the concentrations present.

If the results of UDT are unexpected:

- Contact the laboratory to confirm there was no clerical error.
- Discuss with the laboratory what type of followup test or confirmatory test should be conducted.
- Discuss the results with the patient and document the UDT results and discussion in the patient's medical record.
- Confirm disputed results with the recommended laboratory test.
- Repeated unexpected results suggest the need for evaluation by an addiction specialist.

Intervals for UDT can be either scheduled or random, depending on the patient's risk level.

## **Nonadherence**

Aberrant drug-related behavior (ADRB) is behavior that suggests substance misuse, abuse, or addiction. It includes, among many other behaviors:

- Being more interested in opioids (especially immediate-release and nongeneric) than in other medications or in any other aspect of treatment.
- Taking doses larger than those prescribed or increasing dosage without consulting the clinician.
- Insisting that higher doses are needed.
- Resisting UDT, referrals to specialists, and other aspects of treatment.
- Resisting changes to opioid therapy.

In addition to addiction, ADRB can be driven by other causes, such as:

- Misunderstanding instructions.
- Seeking euphoria.
- Using medications to deal with fear, anger, stress, sleep problems, or other issues.
- Diverting medications for profit.
- Coping with untreated mental disorders.

- Coping with undertreated pain, also known as pseudoaddiction.
- General nonadherence.

Evidence for the validity of tools to help clinicians assess ADRB is limited.

*Complete copies of the following tools are found in TIP 54, Chapter 4:*

- Addiction Behaviors Checklist (Exhibit 4-8)
- Current Opioid Misuse Measure (Exhibit 4-9)

### **Documenting Care**

- Is a Federal and State requirement.
- Permits a determination over time of the extent to which treatment is an asset or a liability to the patient.
- Provides protection for you as the clinician if drug enforcement authorities conduct an investigation.

The University of Wisconsin's Pain and Policy Studies Group maintains a Web site that describes the regulations of different States regarding opioid prescribing (<http://www.painpolicy.wisc.edu>).

## ***Managing Difficult Conversations***

- Listen actively.
- Ask open-ended, nonjudgmental questions.
- Restate a patient's report to make sure it has been understood.
- Use clarification statements (“It sounds as if the pain is worse than usual for you”).
- Demonstrate empathy.
- Use feeling statements (“This must be very difficult for you”).

## ***Workplace Safety***

To protect self and patients from violence in the workplace:

- Be aware of surroundings and report suspicious activity.
- Plan for occasional disruptive or aggressive behavior and position oneself in the examination room between the patient and the door.
- Develop crisis management policies and plans.
- Develop a plan for contacting public-safety officials in urgent or emergent situations.

## **Drug Diversion**

Some patients sell, trade, or give away their medications. Medications taken by people other than to whom they are prescribed are said to be “diverted.” Be alert to the patient who:

- Is known to have contact with people with active SUDs.
- Cannot produce the remainder of a partially used prescription when asked for a pill or patch count.
- Has attempted to alter or forge prescriptions.
- Has been “doctor shopping” to obtain additional medications.
- Does not comply with the nonpharmacological components of recommended treatment.
- Strongly prefers brand name drugs or drugs with high street value.
- Fails to demonstrate the presence of prescribed opioids in appropriate UDT results.

Know which drugs are popular in the community and be vigilant when prescribing medications that have high street value. Also:

- Remind patients of their responsibility to protect medications against theft and diversion.
- Review the Drug Enforcement Agency policy statement on dispensing scheduled medications for the treatment of pain ([http://www.deadiversion.usdoj.gov/fed\\_regs/notices/2006/fr09062.htm](http://www.deadiversion.usdoj.gov/fed_regs/notices/2006/fr09062.htm)).

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- Place strict boundaries around a patient who asks for medications that you as the clinician believe are unwise choices.
- Tighten treatment monitoring if diversion is suspected.
- Cease opioid therapy if serious diversion occurs.
- Monitor patients suspected of doctor shopping via the State prescription monitoring program (<http://www.pmpalliance.org/content/state-pmp-websites>).

### ***Discontinuation of Opioid Therapy***

The best reason to discontinue opioid therapy is that the pain has resolved, but that is often not the case. Other likely reasons for discontinuation include the following:

- Opioids are no longer effective.
- They no longer stabilize the patient or improve function.
- The patient loses control over the medication.
- The patient is diverting the medication.
- The patient is using alcohol, benzodiazepines, or illicit drugs.
- Adverse effects are unmanageable.

Patients tapering off opioids may experience short-term withdrawal (which occurs immediately) and protracted withdrawal.



### Symptoms of opioid withdrawal:

- Abdominal cramps, nausea, vomiting, diarrhea
- Bone and muscle pain
- Anxiety
- Insomnia
- Increased pain sensitivity in the original painful site

### Signs of opioid withdrawal:

- Tachycardia
- Hypertension
- Fever
- Mydriasis
- Hyperreflexia
- Diaphoresis
- Piloerection
- Lacrimation, yawning
- Rhinorrhea
- Myoclonus

Protracted withdrawal from opioids can last for weeks or months, following withdrawal from short- and long-acting opioids. Symptoms of protracted withdrawal include:

- Anxiety
- Depression

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- Sleep disturbances
- Fatigue
- Dysphoria
- Irritability

For patients whose active addiction necessitates discontinuation of opioid therapy, referral for specialized addiction treatment is crucial.

There are many reasons for discontinuing scheduled medications but very few for discontinuing care of the patient. When opioids are a liability, offer to continue to provide non-opioid therapies and treatment.

When electing to discharge a patient from your practice, inform the patient in writing. To avoid charges of abandonment, provide the patient with contact information for other clinicians, along with a written tapering schedule and prescriptions for the medications that require a taper. In cases in which the clinician–patient relationship is hostile or dangerous or in which the patient presents a danger to you, a letter alone can suffice.

*For more detailed information, see TIP 54, Chapter 4.*

## Patient Education and Treatment Agreements

Patient education is necessary for truly informed consent. It also can:

- Improve adherence.
- Help the patient understand medication responses that are expected and normal and those that are of concern and warrant a phone call.
- Allay fears about particular treatments or medications.
- Increase satisfaction with treatment by promoting realistic expectations.
- Provide an opportunity to discuss any concerns.
- Strengthen the clinician–patient relationship by demonstrating respect and enhancing patient feelings of self-efficacy.
- Improve health, well-being, and outcomes.

Effective education:

- Begins at treatment initiation and continues throughout treatment.
- Involves family members, especially caregivers, who play important roles in the patient's treatment.
- Is tailored to each patient's needs.

Educational materials can include information about:

- The patient's condition and the nature of the patient's chronic pain.
- Treatments available, including nonpharmacological options, and risks and benefits.
- Guidance for prescribed medications and/or treatment apparatus (e.g., transcutaneous electrical nerve stimulation machine).
- The degree of pain relief the patient can realistically expect from a treatment.
- How best to use the Internet to find information and sources of support.
- Under what conditions the patient should immediately call you or go to the emergency department.
- How to deal with episodes of acute pain (e.g., from surgery or trauma), as well as flareup pain.

### ***Opioid Information***

To give informed consent, patients must understand:

- Expected benefits as well as uncertainties of chronic opioid therapy, including its limitations in treating long-term CNCP.
- Risks of therapy, including overdose and hazards of combining opioids with sedating drugs or alcohol.

- Expected consequences of extended therapy (e.g., tolerance, physical dependence).
- Issues related to starting, taking, or discontinuing opioid medication.
- Legal and regulatory issues, such as not giving away or selling medication.
- How pain treatment will affect MMT and vice versa (if applicable).

### ***Treatment Agreements***

Treatment agreements are mutually agreed-on plans and courses of action. Involving the patient in planning and writing treatment agreements can preserve patient autonomy while establishing necessary guidelines.

An opioid agreement should include, among other things:

- Goals.
- Risks and benefits.
- Requirements of the patient (e.g., to obtain prescriptions from a single clinician and a named pharmacy).
- Schedule for medical visits and limits on prescriptions.
- Your requirements as clinician to the patient.
- Possible consequences of not following the treatment agreement.

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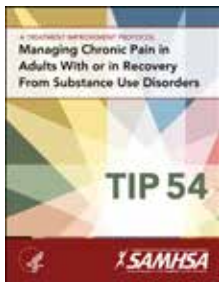
A useful treatment agreement should be revised as the patient's needs and circumstances change.

*For more detailed information, see TIP 54, Chapter 5.*

# Ordering Information

## **TIP 54**

Managing Chronic Pain in  
Adults With or in Recovery  
From Substance Use Disorders



## **TIP 54-Related Products:**

KAP Keys for Clinicians Based on TIP 54

This publication may be ordered or downloaded from SAMHSA's Publications Ordering Web page at <http://store.samhsa.gov>. Or, please call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

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## Other Treatment Improvement Protocols (TIPs) that are relevant to this Quick Guide:

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**TIP 45:** Detoxification and Substance Abuse Treatment

**TIP 43:** Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs

**TIP 40:** Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction

See the inside back cover for ordering information for all TIPs and related products.

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