BASED ON TIP 54

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

KAP KEYS
FOR CLINICIANS

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Introduction

KAP Keys were developed to accompany the Treatment Improvement Protocol (TIP) Series published by the Substance Abuse and Mental Health Services Administration (SAMHSA). These KAP Keys are based entirely on TIP 54 and are designed to meet the needs of the busy clinician for concise, easily accessed "how-to" information.

For more information on the topics in these KAP Keys, see

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

Other TIPs relevant to these KAP Keys:

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

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

TIP 45: Detoxification and Substance Abuse Treatment

Elements of a Comprehensive Patient Assessment

Element	Assessment Factor
Pain and Coping	• Location, character (e.g., shooting or stinging, continuous or intermittent) • Pain types (i.e., nociceptive, neuropathic, mixed) • Lowest and highest extent of pain in a typical day, on a 0 to 10 scale • Usual pain in a typical day, on a 0 to 10 scale • When and how the pain started • Exacerbating factors (e.g., exertion/activity, food consumption, elimination, stress, medical issues) • Palliating factors (e.g., heat, cold, stretching, rest, medications, complementary and alternative treatments) • Prior evaluations to determine the source of pain • Response to previous pain treatments, including complementary and alternative treatments and interventional treatments • Goals and expectations for pain relief
Collateral Information	It is crucial to obtain such information as: • Findings of other clinicians, prior and current • Family concerns, beliefs, and observations • Pharmacist concerns, where relevant • Data from State electronic prescription monitoring programs, if available • Medical records, including psychiatric and substance use disorders (SUDs) treatment records

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Elements of a Comprehensive Patient Assessment (continued)

Element	Assessment Factor
Function	Effect of pain on: • Activities of daily living/ability to care for oneself • Sleep • Mood • Work/household responsibilities • Sex • Socialization and support systems • Recreation • Goals and expectations for restored function
Contingencies	• Family support of wellness versus illness behavior • Vocational incentives and disincentives • Financial incentives and disincentives • Insurance/legal incentives and disincentives • Environmental and social resources for wellness
Substance Use History and Risk for Addiction	• Current use of substances, including tobacco, alcohol, over-the-counter medications, prescription medications, and illicit drugs (confirmed by toxicology) • Focus on opioids to the exclusion of other treatments • Adverse consequences of use (e.g., functional impairment; legal, social, financial, family, work, medical problems) • Age at first use • Treatment history, including attendance at mutual-help groups • Periods of abstinence • Strength of recovery support network (e.g., sponsor, sober support network, mutual-help meetings) • Family history of SUD • History of physical, sexual, or emotional abuse or trauma

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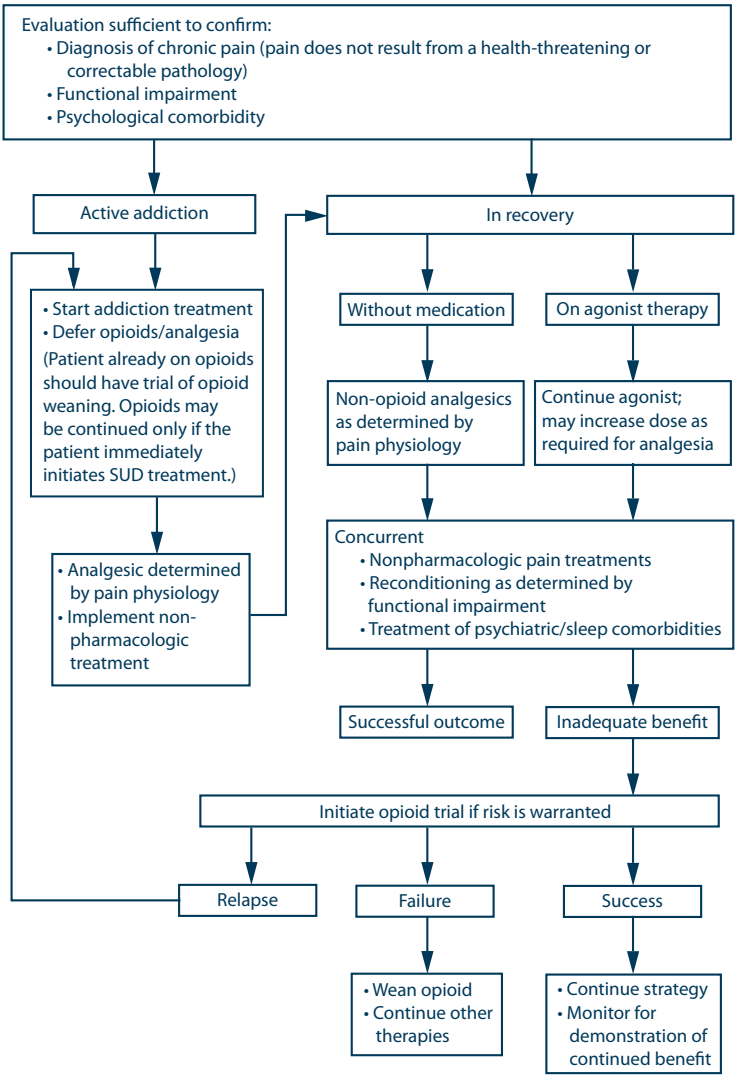
Elements of a Comprehensive Patient Assessment (continued)

Element	Assessment Factor
Co-Occurring Conditions and Disorders	• Psychological conditions (e.g., depression, anxiety, post-traumatic stress disorder [PTSD], somatoform disorders) • Medical conditions (e.g., hepatic, renal, cardiovascular, metabolic) • Cognitive impairments (e.g., dementia, delirium, intoxication, traumatic brain injury)
Physical Exam	• Relevant associated signs of pain disorder • Signs of substance abuse (e.g., track marks, hepatomegaly, residua of skin infections, nasal and oropharyngeal pathology)
Mental Status	• Medication focused • Somatic preoccupation • Mood • Suicidal ideation and behavior • Cognition (e.g., attentional capacity, memory)

Algorithm for Managing Chronic Pain in Patients With SUDs



Summary of Non-Opioid Analgesics

Analgesic	Addictive	Notes
Acetaminophen	No	Should normally not exceed 4 g/day; in adults with hepatic disease, the maximum dose is 2 g/day. Potentiates analgesia without potentiating respiratory and sedative side effects.
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	No	Are used to relieve numerous types of pain, especially bone, dental, and inflammatory, and enhance opioid analgesia. May cause gastrointestinal bleeding and renal insufficiency.
Serotonin-Norepinephrine Reuptake Inhibitors	No	Are used to relieve several nonstructural types of pain (e.g., migraine, fibromyalgia, low back pain) and probably others.
Tricyclic Antidepressants	No	Have demonstrated efficacy in migraine prophylaxis, fibromyalgia, many neuropathic pains, vulvodynia, and functional bowel disorders. Watch for anticholinergic side effects and orthostatic hypotension (fall risk in older people).
Anticonvulsants	No	Some have demonstrated efficacy in relieving fibromyalgia, migraine prophylaxis, and neuropathic pains.
Topical Analgesics	No	Comprise several unrelated substances (e.g., NSAIDs, capsaicin, local anesthetics). Work locally, not systemically, and therefore usually have minimal systemic side effects.

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Summary of Non-Opioid Analgesics (continued)

Analgesic	Addictive	Notes
Antipsychotics	No	Have no demonstrated analgesic effect, except to abort migraine/cluster headache. Risks include extrapyramidal reactions and metabolic syndrome.
Muscle Relaxants	Carisoprodol (Soma) is addictive. Some others have significant abuse potential.	Have not been shown to be effective beyond the acute period. Some potentiate opioids and are not recommended.
Benzodiazepines	Yes	Not recommended (see TIP 54, pp. 35–36).
Cannabinoids	Yes	Not recommended (see TIP 54, p. 37).

Steps To Take if Opioid Therapy Is Indicated

Step 1. Educate patient and family about treatment options, sharing the decision about the goal and expected outcome of therapy.

Step 2. Discuss treatment agreement with the patient and family.

Step 3. Obtain a written opioid agreement.

Step 4. Determine and document the treatment plan.

Step 5. Initiate a trial of opioid therapy.

Step 6. Document details of therapy and results.

Source: Department of Veterans Affairs & Department of Defense, Management of Opioid Therapy for Chronic Pain Working Group. (2010). *VA/DoD clinical practice guideline for management of opioid therapy for chronic pain*. Washington, DC: Department of Veterans Affairs, U.S. Department of Defense.

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.

Ten Steps of Universal Precautions

Clinicians should adopt a universal precautions approach toward their patients who have chronic noncancer pain (CNCP). The term *universal precautions* first emerged in the context of infectious disease treatment and referred to using infection control procedures with all patients. 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. A universal precautions approach improves care and shows due diligence in an era of increasing illegal use of prescription opioids.

1. Make a diagnosis with appropriate differential.
2. Perform a psychological assessment, including risk of addictive disorders.
3. Obtain informed consent.
4. Use a treatment agreement.
5. Conduct assessments of pain level and function before and after the intervention.
6. Begin an appropriate trial of opioid therapy with or without adjunctive medications and therapies.
7. Reassess pain score and level of function.
8. Regularly assess the "4A's" of pain medication.
9. Periodically review pain diagnosis and co-occurring conditions, including addictive disorders.
10. Document initial evaluation and followup visits.

Source: Gourlay, D. L., Heit, H. A., & Almahrezi, A. (2005). Universal precautions in pain medicine: A rational approach to the treatment of chronic pain. *Pain Medicine, 6*(2), 107–112. Adapted with permission.

Addiction Behaviors Checklist

Addiction Behaviors Since Last Visit

Item	Yes	No	Not Assessed
1. Patient used illicit drugs or evidences problem drinking			
2. Patient has hoarded medication			
3. Patient used more opioids than prescribed			
4. Patient ran out of medications early			
5. Patient has increased use of opioids			
6. Patient used analgesics PRN (as needed) when prescription is for time-contingent use			
7. Patient received opioids from more than one provider			
8. Patient bought medications on the streets			

Addiction Behaviors Within Current Visit

Item	Yes	No	Not Assessed
1. Patient appears sedated or confused (e.g., slurred speech, unresponsive)			
2. Patient expresses worries about addiction			
3. Patient expresses a strong preference for a specific type of analgesic or a specific route of administration			
4. Patient expresses concern about future availability of opioid			
5. Patient reports worsened relationships with family			
6. Patient misrepresents analgesic prescription or use			

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Addiction Behaviors Checklist (continued)

Addiction Behaviors Within Current Visit (continued)

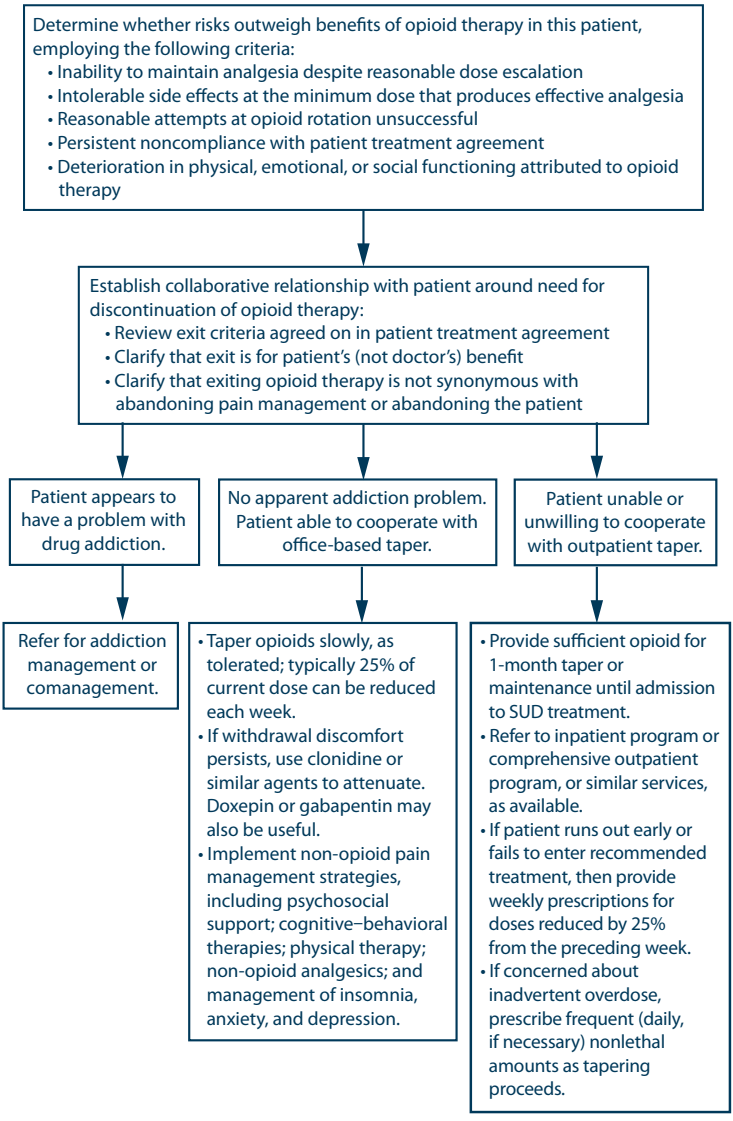
Item	Yes	No	Not Assessed
7. Patient indicates she or he "needs" or "must have" analgesic medications			
8. Discussion of analgesic medications is the predominant issue of visit			
9. Patient exhibits lack of interest in rehabilitation or self-management			
10. Patient reports minimal/inadequate relief from opioid analgesic			
11. Patient indicates difficulty with using medication agreement			

Other

Item	Yes	No	Not Assessed
1. Significant others express concern over patient's use of analgesics			

Source: Wu, S. M., Compton, P., Bolus, R., Schieffer, B., Pham, Q., Baria, A., et al. (2006). The Addiction Behaviors Checklist: Validation of a new clinician-based measure of inappropriate opioid use in chronic pain. *Journal of Pain and Symptom Management, 32*(4), 342–351. Adapted with permission.

Discontinuation of Opioid Therapy—Exit Strategy



Ordering Information

TIP 54
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TIP 54-Related Products:
Quick Guide 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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