THE INTERSECTION OF PAIN & SUBSTANCE USE DISORDER:

HOW TO ASSESS & NAVIGATE THE TRAFFIC

PRESENTED BY

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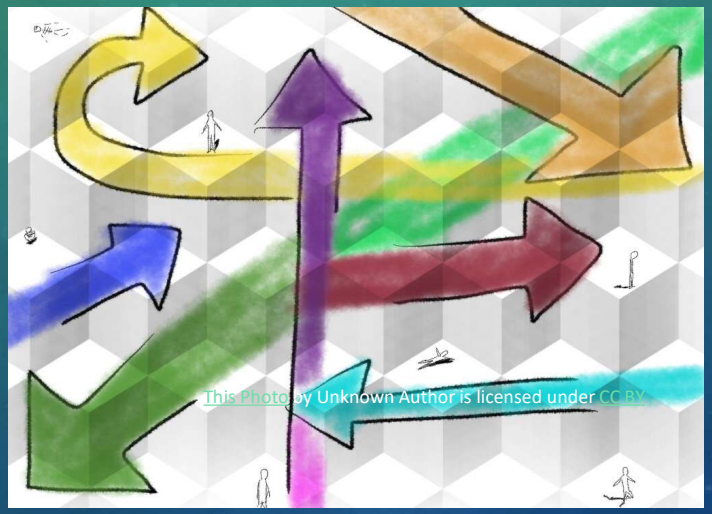
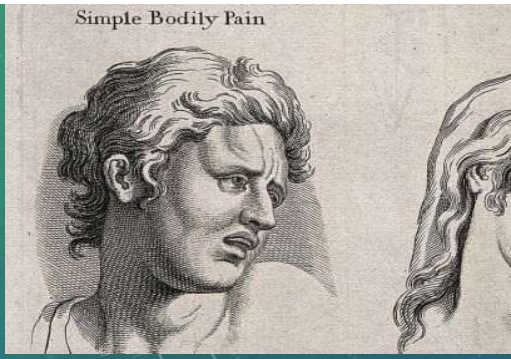
PRESIDENT AMERICAN ASSOCIATION FOR PAIN MANAGEMENT NURSING

THE PROBLEM:
A BIDIRECTIONAL & COMPOUNDING EFFECTS

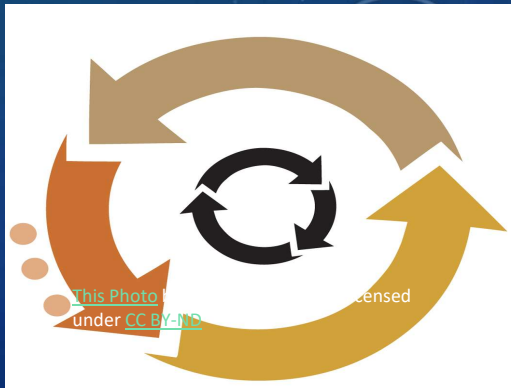


WHICH CAME FIRST, SECOND, THIRD?????

A PAINFUL LOOK

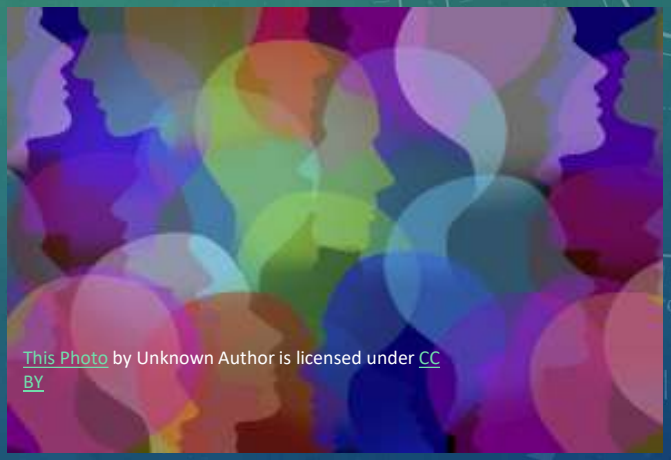


- Pain populations --- higher depressive symptoms (Schaffer, 2023)
- Depressive populations --- higher pain symptoms
  - 65% Depressed pt w/ higher pain report than general population (Ferguson et. al. 2021)
  - Leads to poorer prognosis for both conditions w/ co-occurrence
- Chronic Substance use raises risk for
  - Depresssion, anxiety, anhedonia, dysphoria (Ferguson 2021)
  - Chronic ETOH & opioid use disorder may sensitize nociception (Schaffer, 2023)
  - Withdrawal symptoms heighten pain/depression
- SO…
  - pain leads to mental health problems
  - Mental health problems lead to pain
  - Substance Use leads to mental health problems & possibly pain

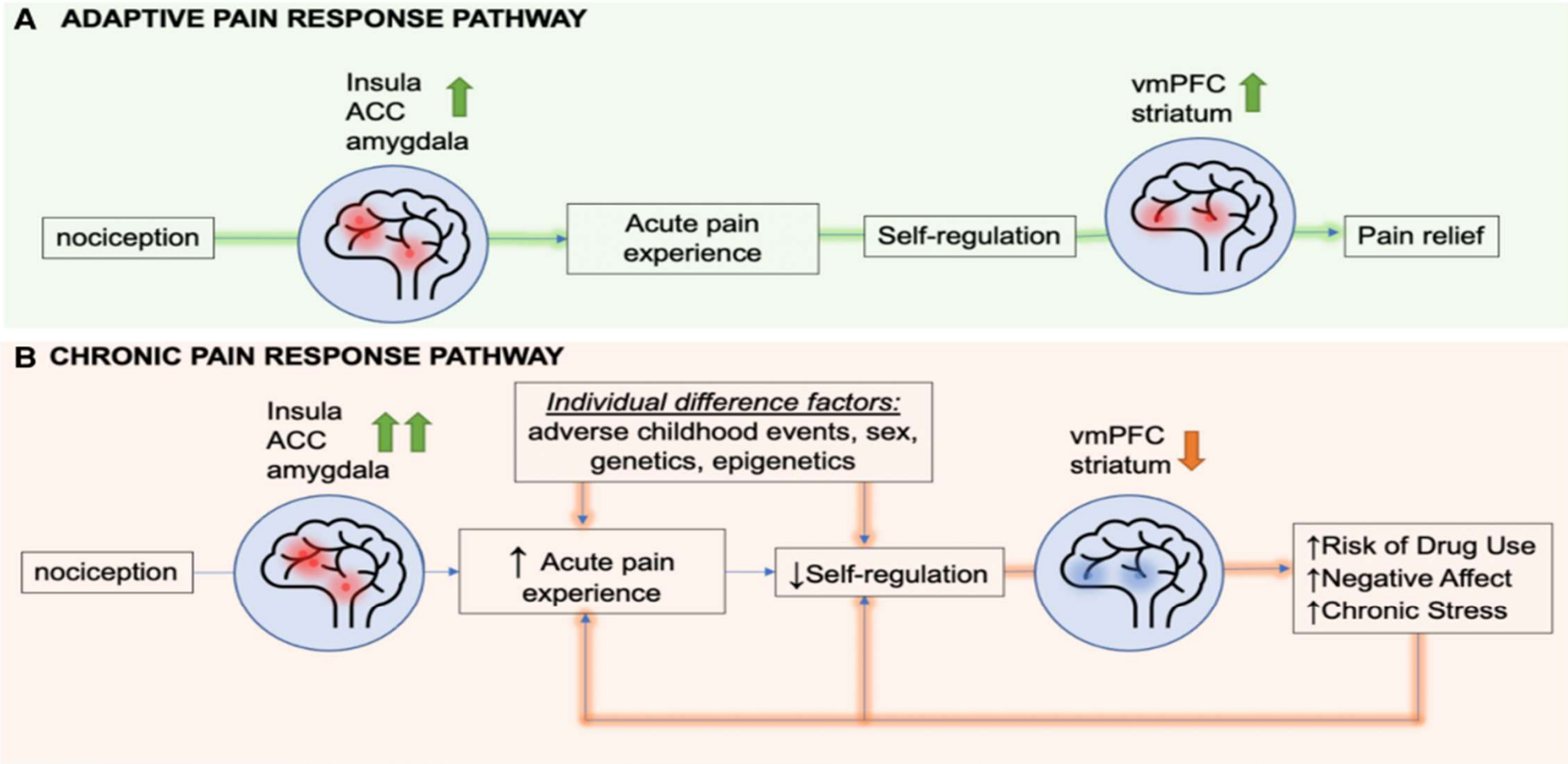


ADD OVERLAPPING MECHANISMS..PAIN..STRESS..SUD

- Ventromedial prefrontal cortex regulates (Schaffer et al, 2023)
  - Pain (chronic)
  - Stress
  - SUD
- Co-morbidities Raising risk of Chronic Pain
  - Long-term/chronic stress OR unpredictable stress
  - ACE childhood events
    - Epigenetic changes for pain thresholds
  - Sex/Gender
    - Animal models- Female mice w/ higher morphine need than Male for same injury
    - Less activation of endogenous opioids
    - Endocannabinoid system- more activation but faster tolerance (affects pain/stress/coping)
    - Women suffer health problems at lower ETOH levels than men

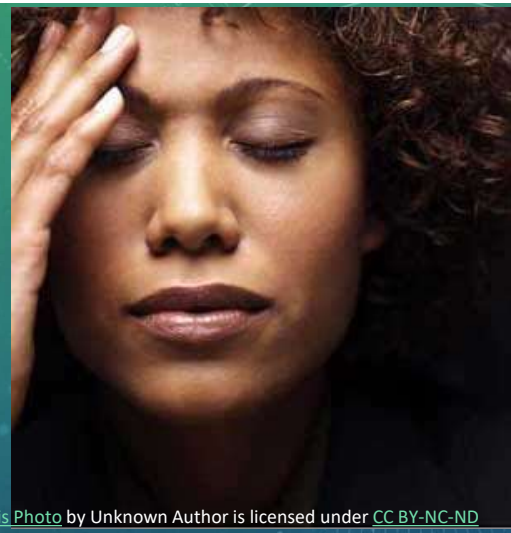


https://www.niaaa.nih.gov/health-professionals-communities/core-resource-on-alcohol



Schaffer et al., 2023

ADD CATASTROPHIC THINKING



- Pain Catastrophizing
  - Repetitive negative thought disorder w..
  - Rumination
  - Magnification
  - Helplessness re: actual or anticipated pain
- Robust literature - can increase pain intensity/interference and mood disorders
- CAUTION:
  - Topic may invite defensive patient response
    - Fear of dismissal of symptoms/treatment
  - Use in Biopsychosocial Framework
    - Mind & body influence each other
    - EBP- castrophizing can heighten pain/mood disorders– but not as primary cause

(Sullivan et al., 1995; Brown et al.,2020, Sullivan & Tripp 2024)

PAIN CATASTROPHIZING SCALE

HTTPS://WWW.OREGON.GOV/OHA/HPA/DSIPMC/PAINCARETOOLBOX/PAIN%20CATASTROPHIZING%20SCALE.PDF

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

Instructions:
We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

RATING	0	1	2	3	4
MEANING	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time

When I'm in pain ...

Number	Statement	Rating
1	I worry all the time about whether the pain will end.	
2	I feel I can't go on.	
3	It's terrible and I think it's never going to get any better	
4	It's awful and I feel that it overwhelms me.	
5	I feel I can't stand it anymore	
6	I become afraid that the pain will get worse.	
7	I keep thinking of other painful events	
8	I anxiously want the pain to go away	
9	I can't seem to keep it our of my mind	
10	I keep thinking about how much it hurts.	
11	I keep thinking about how badly I want the pain to stop	
12	There's nothing I can do to reduce the intensity of the pain	
13	I wonder whether something serious may happen.	

Source: **Sullivan** MJL, **Bishop** S, **Pivik** J. The **pain catastrophizing scale**: development and validation. *Psychol Assess*, **1995**, 7: 524-532

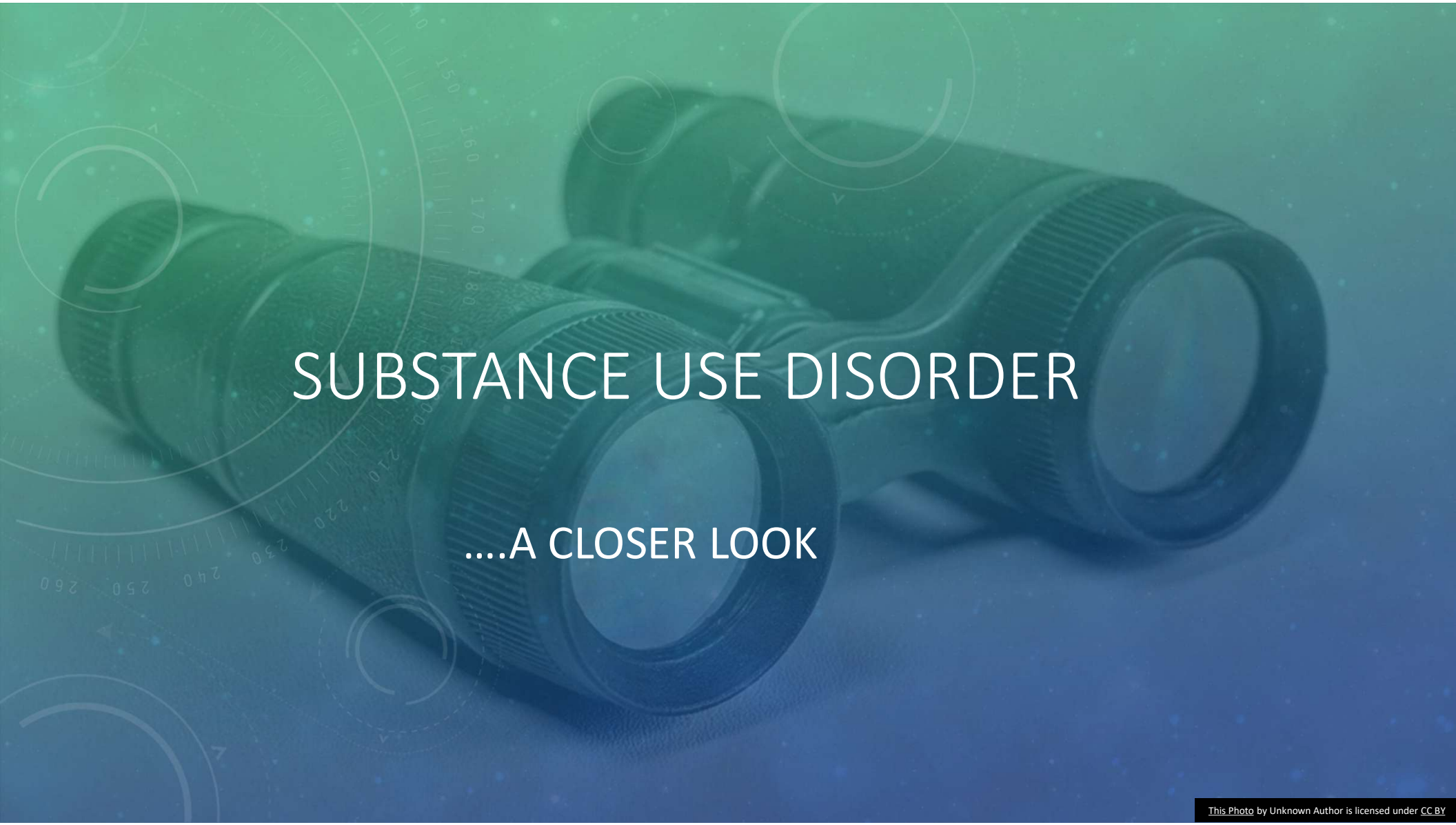
ADD SOCIAL EFFECTS

- Social Isolation linked to Loneliness
- Loneliness = same health risk as smoking 15 cigarettes/day, heavy alcohol use, HTN, obesity

  https://knowledge.wharton.upenn.edu/article/science-kindness-harding-book/
- Opioids temporarily lower pain of loneliness (Schaffer, 2023)
- Health conditions linked to social isolation
  - Chronic pain
  - Depression/anxiety
  - SUD

ADDS UP TO…

- A complex interplay of multiple factors that effect & reinforce each other
- People often need relief of both physical and emotional/mental pain
- Individualized differences in one or more contributing factors
  - varying risk for chronic pain/mental health problems / SUD



SUBSTANCE USE DISORDER

….A CLOSER LOOK

SUBSTANCE USE DISORDER …..

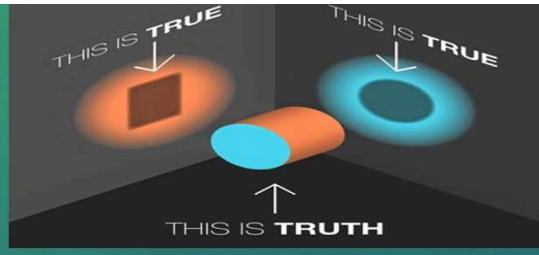
IS NOT

- Simply a disease of exposure
- The same as medication misuse
- A moral failing

IS

- An interplay of multiple factors
  - Genetic
  - Uncontrolled Psychiatric factors
  - Social/Spiritual/Relational stress
  - Environmental Insecurity
  - Exposure to a rewarding substance

THE PROBLEM IN PERSPECTIVE!



Alcohol

- ✓ 27.9 million people w/ AUD
- ✓ 178,307 deaths avg/year r/t ETOH

32 % of MVA deaths 2022 (13,524 deaths)

National Institute on Alcohol Abuse and Alcoholism www.niaaa.nih.gov

https://www.samhsa.gov/data/nsduh/reports-detailed-tables-2024-NSDUH

https://drugabusestatistics.org/alcohol-abuse-statistics/

Opioids

- 9.3 million w/ OUD (3.7% population)
- 2017 = 2.1 million w/ OUD
  - 1.7 million w/ "pain reliever use disorder" (2017 NSDUH)
- 54,743 deaths 2024 r/t opioids
  - NOTE: 80,391 deaths 2024 r/t any drug OD
  - 110,037 deaths 2023
- ***Smaller numbers - but higher attention!***
-

NATIONAL SURVEY ON DRUG USE& HEALTH(NSDUH)2025

Figure 7. Alcohol Use, Binge Alcohol Use, or Heavy Alcohol Use in the Past Month: Among People Aged 12 or Older; 2024

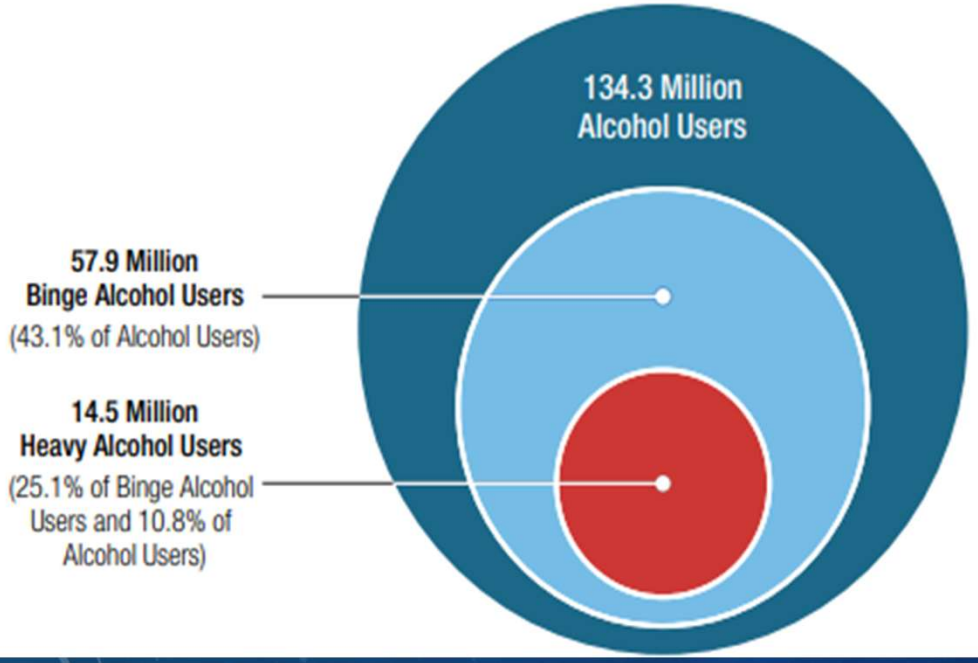
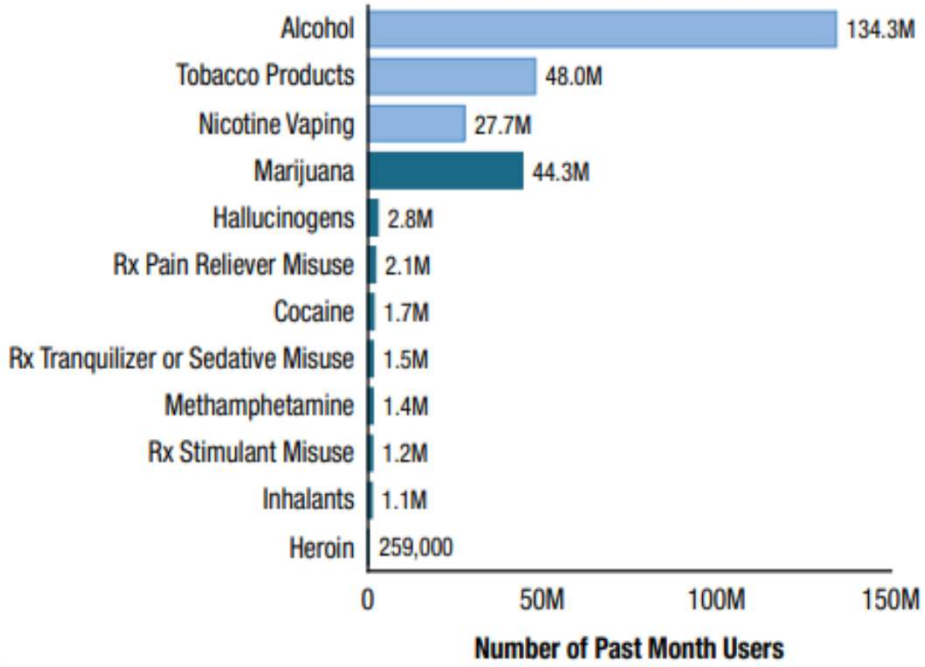


Figure 1. Past Month Substance Use: Among People Aged 12 or Older; 2024



SAMHSA
Substance Abuse and Mental Health Services Administration

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- **About**
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- SAMHSA Strategic Priorities
- Regional Offices
- Offices and Centers
- Advisory Councils
- News and Announcements
- Budget

2025 Alcohol Awareness Month

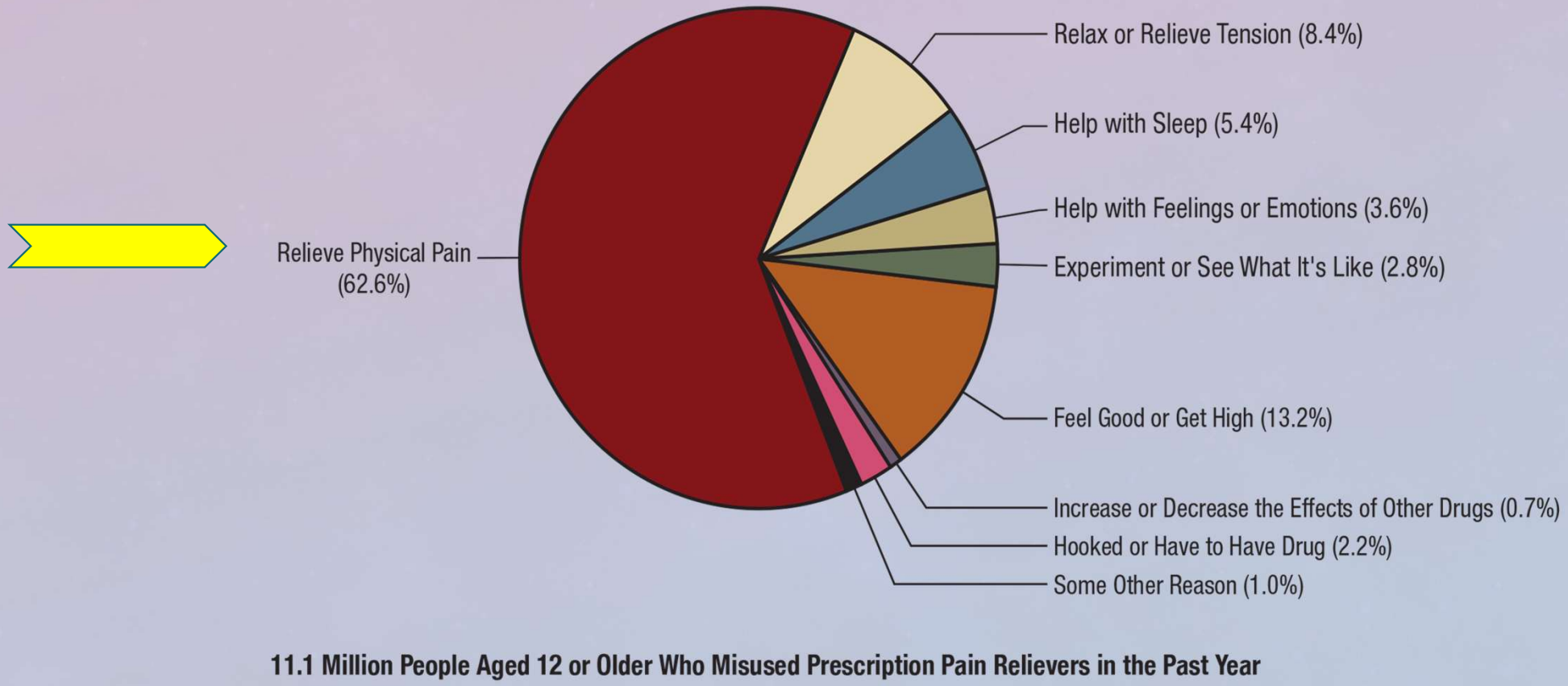
April is Alcohol Awareness Month—a time to raise awareness and understanding of alcohol use and misuse. It offers communities a chance to gain more understanding of how individuals struggle with alcohol use and offers resources and support.

NON-MEDICAL PAIN RELIEVER (NMPR) USE

- Definition – old title of misuse/abuse of opioid prescription
  - Using in any way other than directed/prescribed
    - Overuse, change of route, different reason than prescribed(i.e opioids for sleep)
    - Use of left-over meds, or Rx not prescribed to you
    - For “experience” or “feeling” obtained
  - Varies from minor to major infractions
- Incidence in general population
  - 7.6million (USDUH 2021-2024) = 2.8% of population
    10.5 million NMPR (NSDUH 2017) = 3.2 % of population

FFR1.25

WHY DO IT? MAIN REASON FOR THE MOST RECENT PRESCRIPTION PAIN RELIEVER MISUSE AGES 12 OR OLDER IN THE PAST YEAR: NSDUH 2017 (NATIONAL SURVEY ON DRUG USE & HEALTH)



11.1 Million People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year

Note: The percentages do not add to 100 percent due to rounding.

WHY DO IT? MAIN REASON FOR THE MOST RECENT PRESCRIPTION PAIN RELIEVER MISUSE (NSDUH 2024)

Table A.15B Main Reason for the Last Episode of Misuse: Among People Aged 12 or Older Who Misused Prescription Pain Relievers in the Past Year; 2024

Main Reason for Misuse	Past Year Misusers of Prescription Pain Relievers	
Relieve Physical Pain	70.1	(1.82)
Relax or Relieve Tension	7.5	(1.00)
Help with Sleep	3.0	(0.58)
Help with Feelings or Emotions	2.3	(0.43)
Experiment or See What It's Like	2.1	(0.66)
Feel Good or Get High	9.1	(1.03)
Increase or Decrease Effect of Other Drug	1.3	(0.54)
Because I Am Hooked or Have to Have It	3.1	(0.61)
Some Other Reason	1.6	(0.40)

WHY DO WE CARE ABOUT MISUSE?

SAFETY

RISK FOR SUBSTANCE USE DISORDER

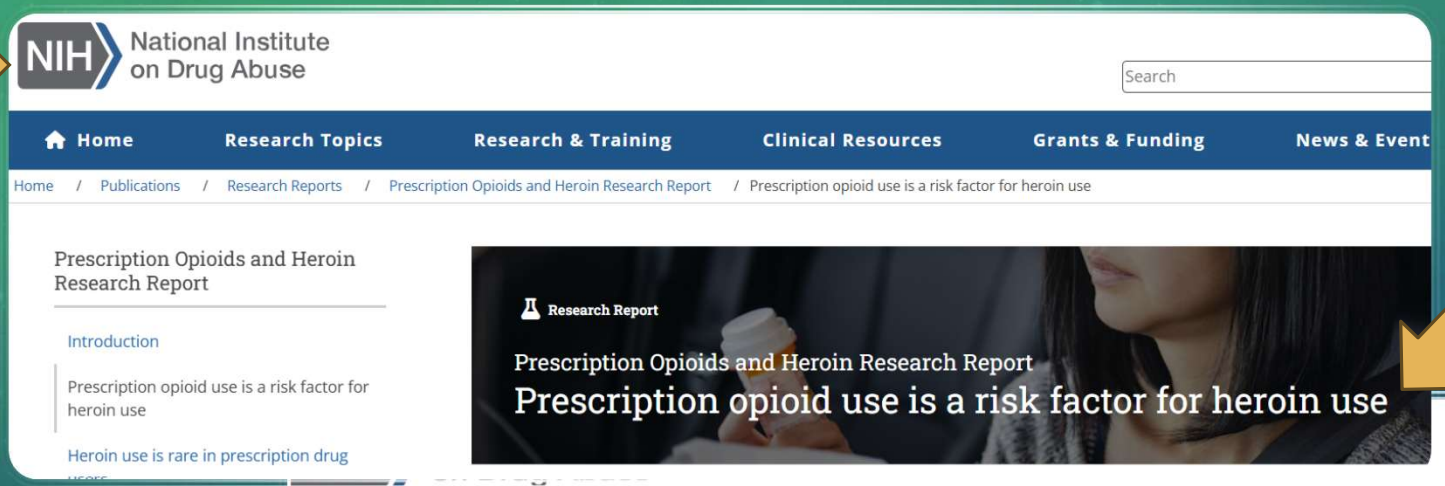
Concern for script opioids and/or NMPR use leading to heroin use

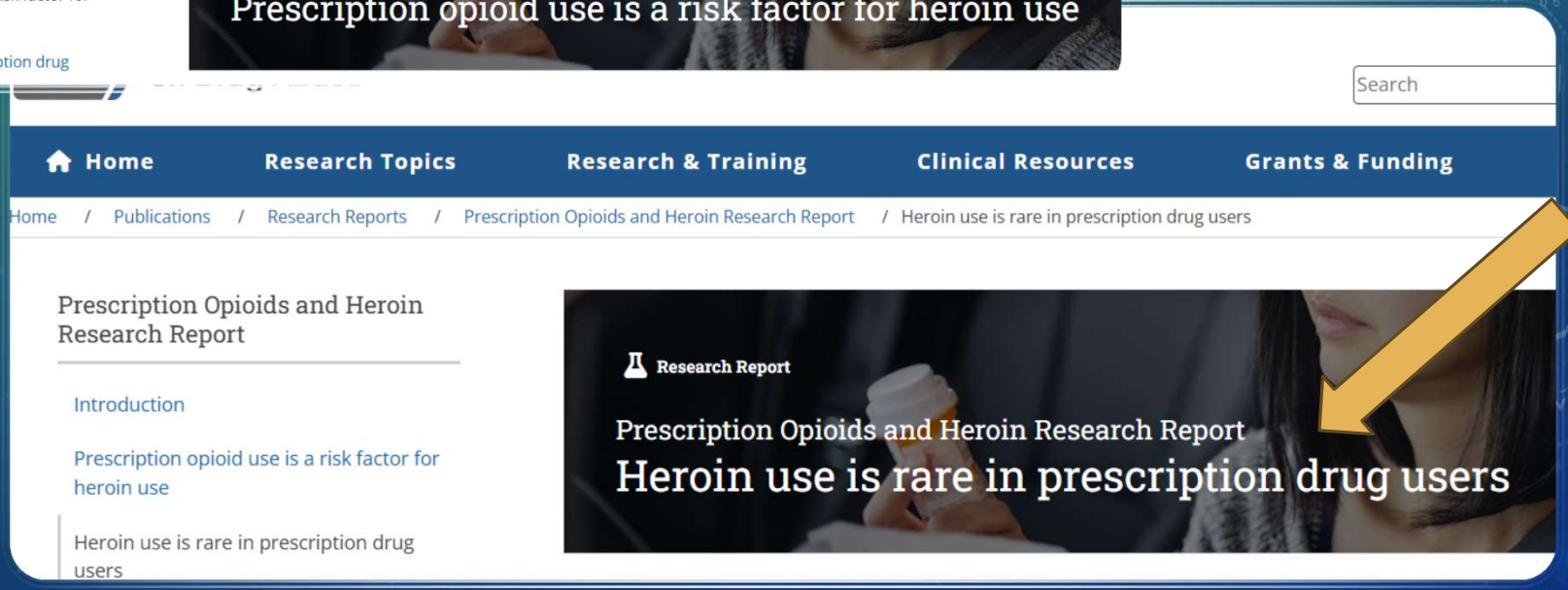
PRIOR MISPERCEPTION

- Prescription opioid use leads to heroin/illicit drug use

- FACTs:
- 19x higher risk for starting heroin use w/ NMPR hx
- But less than 4% of opioid Rx NMPR started heroin within 5 yr
- Prescription Opioids used as directed show no specific risk of leading to SUD
  - Some individuals at higher risk than others
- ADD rates of Rx opioid OD hx????
  - Opioid prescriptions have decreased (PDF) 52% since 2012, falling from 260.5 million to 125.7 million in 2024.

READ THOROUGHLY!





NIDA,nih.gov,2018

SECOND LOOK AT NSDUH & NMPR

- 3 types of script opioid users w/ NMPR use
  - 1) misuse own Rx only 2) misuse Rx w/o a prescription 3) misuse own /others/street Rx drugs
  - Type #3 had highest rate of heroin use
- Misusers were more likely to…
  - Be Depressed
  - Have hx alcohol use disorder
  - Have higher rates of a " use disorder' for marijuana, script opioids, heroin, BZD
  - Perceive Rx drug use as less risky

- **<u>Authors Conclusion</u>**; Approaches to reduce harm from script opioids must evaluate differences in types of NMPR users
- MOST NMPR responds to education & adherence monitoring

From Columbia University School of Public Health (Griesler et al. Am J Pub Hlth, 2019)

A NEW FRAMEWORK OF ADDICTION

Alexander et. al., 1981

RATS IN A CAGE!

- Prior Experiments - Solitary Caged Rat
- Access to clean water and “spiked” water w/ morphine
- Frequent display of compulsive “spiked” water consumption
- Many died of morphine consumption
- Rat Park
  - Simulated natural, social environment
  - Access to clean water and “spiked” water
  - **Low use of “spiked” water; no deaths**

RAT PARK MORPHINE CONSUMPTION

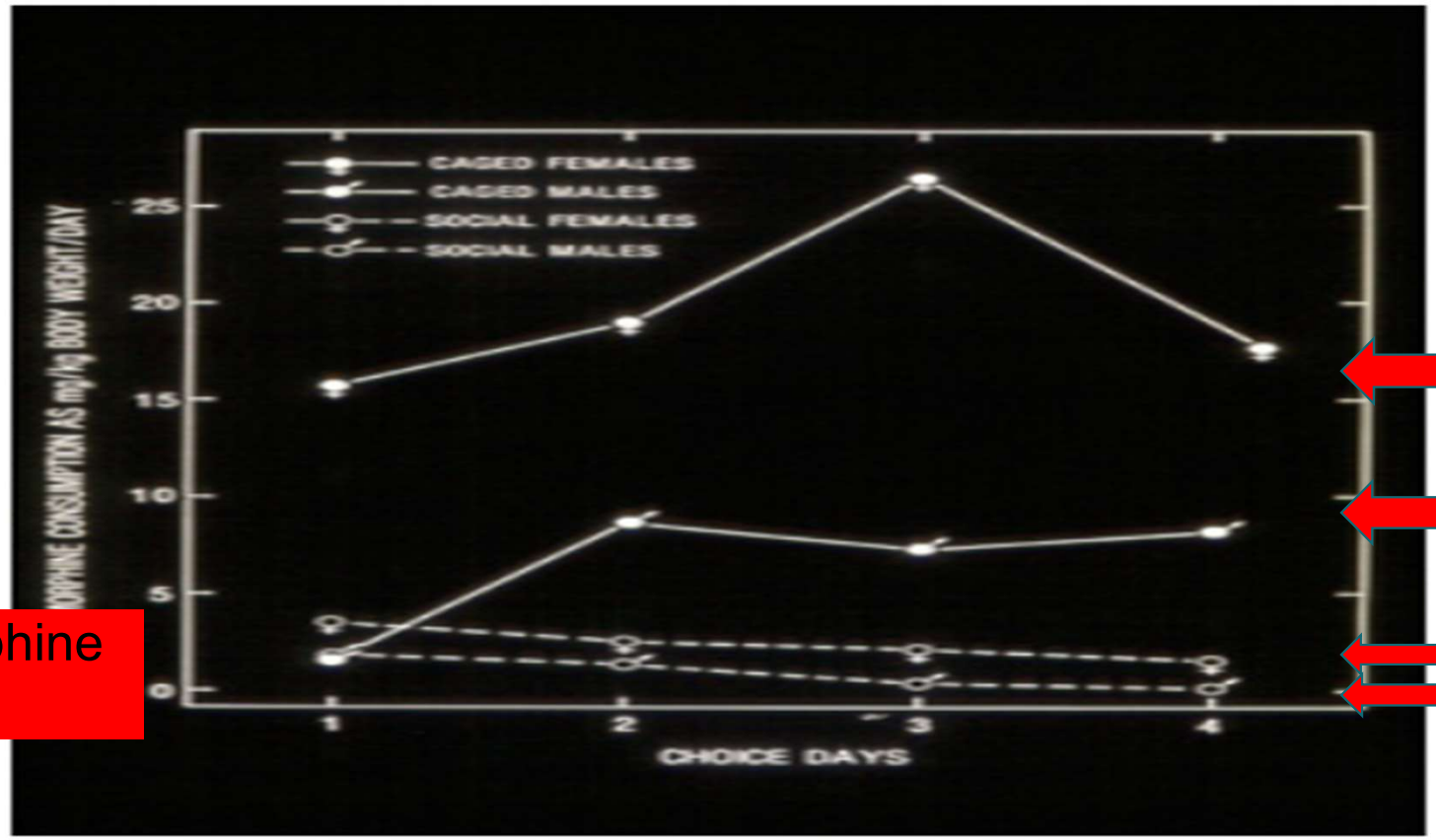


Fig 7 - Some Experimental Results

Morphine Use

Caged Females

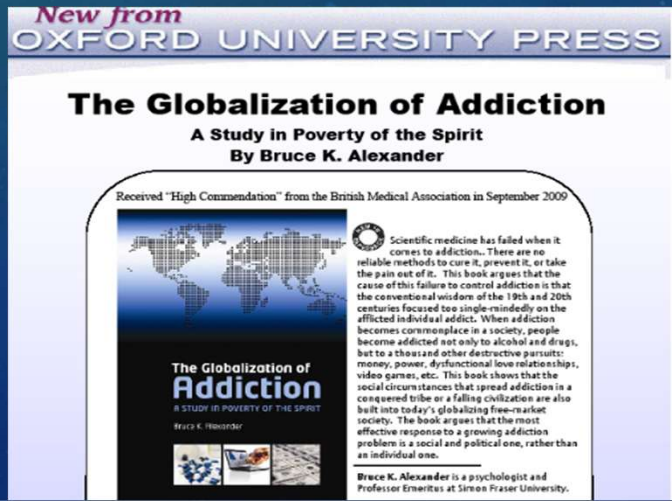
Caged Males

Social Females

Social Males

RAT PARK CONCLUSIONS: A THEORY OF ADDICTION

- Isolation bred addiction
  - Addicted rats recovered once returned to community
- Addiction is not a moral failing, or disease of exposure, or only genetics or “brain disease”
- Addiction is a poverty of spirit and disconnection from community- built into modern society
- Opposite of Addiction:
  - Connection
  - Belonging
  - Meaning
- Resistance to theory –
  - need to blame someone for the crises desire for simple answers



RAT PARK STUDY REPRODUCIBILITY DEBATE (KHOO, 2020)

- Repeat animal studies w/ variable results
  - Variable strains of rats
  - Variable morphine type (Morphine sulfate vs Morphine HCL)
- Some methodological errors in original study
  - Rats dying
  - Some days of data lost
- Multiple subsequent studies w/ varying approaches affirm similar conclusions
  - Social/environmental enrichment is OFTEN protective against SUD
    - A minority of animals still prefer the drug
    - Isolated animals (esp early age) changes the sensitivity to opioids (require higher doses)

GLOBAL RESPONSES

FROM "CHASING THE SCREAM" BY JOHANN HARI, 2015

- "The heroin addict has bonded with heroin because she couldn't bond as fully with anything else" – (Johann Hari, 2015)

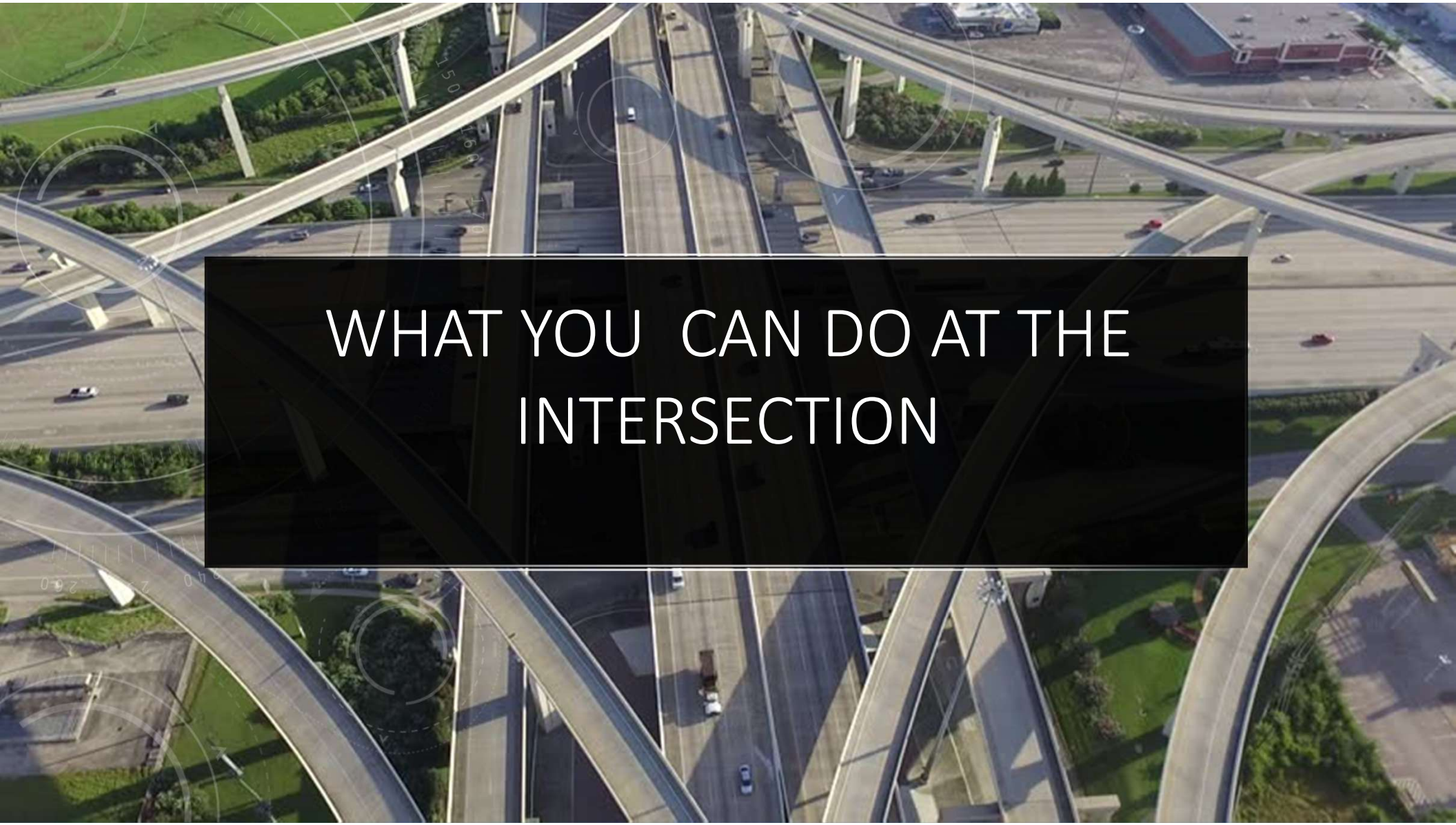
- *Portugal* – late 1990s/ early 2000s
  - Large heroin problem; 1% of population addicted
  - Decriminalized all drugs AND provided housing & job training/placement
  - Provided start up loans for businesses
  - Subsidized employers x 1 year if hired SUD recovered person
  - Studied by British Journal of Criminality – injecting drug use DOWN 50% after these policies

SWITZERLAND & SUD

- 1987 - Zurich “needle park” 1000 drug users/day convened
- 1990s policy & program changes
  - Needle exchange, injection rooms, SUD Rx, housing & employment programs
  - Zurich- heroin users declined by 82% from 1990 to 2002
  - Methadone & Heroin maintenance programs
  - Crime reduction- lower contact w/ “street drug scene,” no need to buy drugs
  - Lower HIV, Hepatitis and lower health care costs
- “Medicalization“ of heroin made it unattractive to young people (Nordt et al., Lancet, 2006)
  - Population of medication-assisted programs is aging w/ fewer young people
  - http://drugwarfacts.org/region/switzerland

Take a Listen!

Hari, J. (2015). Everything you think you know about addiction is wrong. *TED Talks, uploaded by TED*, *9*.


WHAT YOU CAN DO AT THE INTERSECTION

ACUTE PAIN & SUD

Higher Doses r/t opioid tolerance	• Uncontrolled acute pain raises risk of SUD relapse/resumption • You are NOT adding to their addiction
Non-opioids Meds	• Maximize non-opioids/ schedule them
Consider Ketamine	• May lower tolerance/NMDA inhibition for improved analgesia
Discharge Planning	• Supervised setting or involve trustworthy family members as needed
Consult	• Psychology/Psychiatry/Addiction Psychiatry
Converse w/ patent on SUD hx	• Ask permission • Humanizes patient & develops therapeutic relationship

CLASSIC APPROACH : 10 UNIVERSAL PRECAUTIONS W/ CHRONIC PAIN

1) Define pain diagnosis

2) Psychological & SUD assessment

3) Informed Consent (pt ed on risks/benefits)

4) Written Treatment Agreement (duties pt/HCP)

5) Eval pain & function pre/post Rx

6)Appropriate trial of opioids +/- adjuncts

7) Reassess pain & function

8) Regularly assess 5 A's-

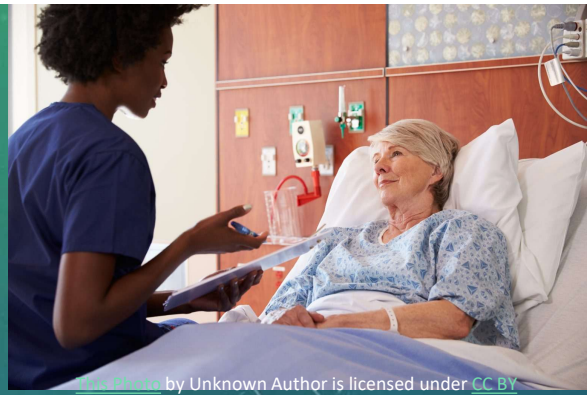
- Analgesia
- Activity
- Adverse effects
- Aberrant behavior
- Affect

9) Regular review of pain & comorbid dx

10)Documentation

(Adapted from Gourlay, et al., 2005)

MENTAL HEALTH SCREENING



- Screening = asking one or more questions about mental health
  - Informal questions
  - Many published screening tools
- Routine screening for depression/anxiety recommended-USDHHS (2019)
  - IF concurrent SUD – delay definitive diagnosis till 1 month abstinence (APA, 2013)
- PTSD
  - 10% all pts w/ chronic pain;
  - 50% of chronic pain pts w/ hx MVA or military combat
- ACE – linked w/ persistent pain, depression, risky behaviors, SUDs (CDC 2020,Nelson 2017, Schrepf 2018
- Spiritual Health– sense of purpose/meaning/belonging
  - Aids w/ acceptance and pain tolerance (Vasigh,2020)

SCREENING FOR SUBSTANCE USE

Definition: asking one or more questions about substance use

- Informal questions
- Many published screening tools
  - SAMHSA, NIDA online sources for tool access

SBIRT approach (Screening, brief intervention, referral to treatment)

- A public health approach for identification and early intervention of substance use/misuse/SUD risk
- Widely recommended
  - U.S. Preventive Services Task Force (USPSTF) 2020 for routine screening of adults
  - SAMHSA (Substance Abuse & Mental Health Administration, 2020)
  - Am Academy of Pediatrics routine screening adolescents (Levy ,2016)

SBIRT TOOLS FOR PROVIDERS (SCREENING): NY STATE WEBSITE

Common Pre-screening Tools:

- AUDIT-C - consists of three questions related to drinking frequency and quantity. The higher the score, the more likely alcohol is affecting the individual's health and safety. Audit-C questions are a subset of the full 10-question Audit | AUDIT-C in Spanish | Full 10-question Audit in Spanish
- DAST 1: The DAST-1 refers to the first question of the DAST-10. It asks: "In the last 12 months, have you used drugs other than those required for medical reasons?" Positive responses should be followed up with the full DAST-10 also available in Spanish.
- NIAAA Single Alcohol Screening Question (SASQ): "How many times in the past year have you had (4 for women, or 5 for men) or more drinks in a day?" Responses of one or more should be followed by full screen.
- NIDA Single Question Screening Test for Drug Use: "How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons (for example, because of the experience or feeling it caused)?" Responses of one or more should be followed up by full screen.
- Substance Use Brief Screen (SUBS): "How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?" Responses of one or more should be followed by full screen.

https://oasas.ny.gov/sbirt

WHY USE SBIRT?

Missed Opportunities

Most patients (68-98%) with alcohol abuse or dependence are not detected by healthcare professionals.

- Healthcare professionals are less likely to detect alcohol problems:
  - When screening tools are not used universally
  - In patients who they do not expect to have alcohol problems: Whites, women, and those of higher SES

Adapted from The Oregon SBIRT Primary Care Residency Initiative training curriculum (www.sbirtoregon.org)

Patients **Are** Open To Discussing Their Substance Use To Help Their Health

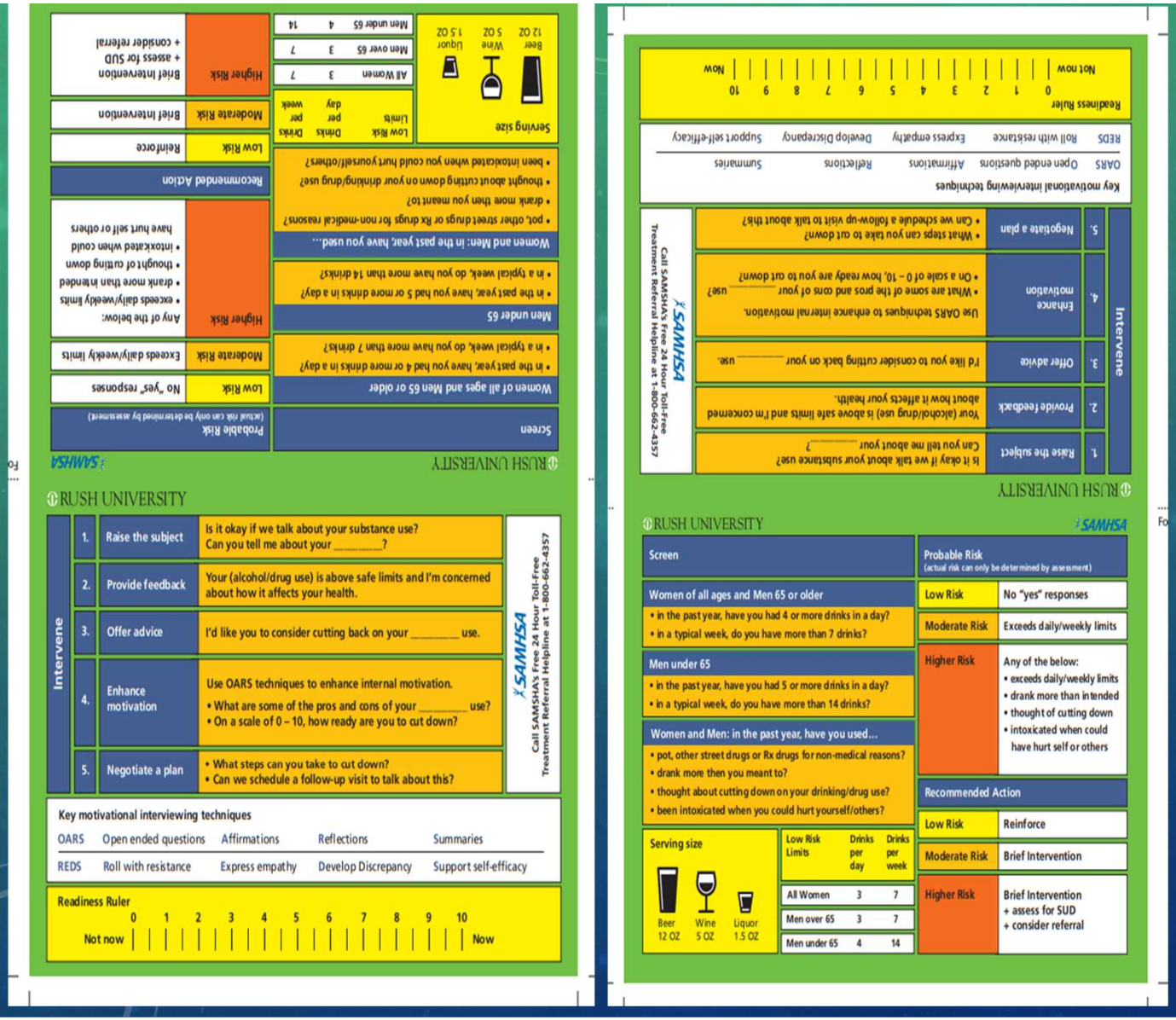
Survey of Patient Attitudes

	Agree/Strongly Agree
"If my doctor asked me how much I drink, I would give an honest answer."	92%
"If my drinking is affecting my health, my doctor should advise me to cut down on alcohol."	96%
"As part of my medical care, my doctor should feel free to ask me how much alcohol I drink."	93%
	Disagree/Strongly Disagree
"I would be annoyed if my doctor asked me how much alcohol I drink."	86%
"I would be embarrassed if my doctor asked me how much alcohol I drink."	78%

Adapted from The Oregon SBIRT Primary Care Residency Initiative training curriculum (www.sbirtoregon.org)

PATIENTS WILL SHARE IF ASKED.

- But likely not to volunteer the info



SBIRT Pocket Card
Rush University Psychiatry Dept

https://www.rushu.rush.edu/rush-medical-college/departments/department-psychiatry-behavioral-sciences/section-addiction-medicine/sbirt-screening-brief-intervention-referral-treatment/sbirt-pocket-card

SAMHSA

RUSH UNIVERSITY

Intervene

1.	Raise the subject	Is it okay if we talk about your substance use? Can you tell me about your _____?
2.	Provide feedback	Your (alcohol/drug use) is above safe limits and I'm concerned about how it affects your health.
3.	Offer advice	I'd like you to consider cutting back on your _____ u
4.	Enhance motivation	Use OARS techniques to enhance internal motivation. • What are some of the pros and cons of your _____ • On a scale of 0 – 10, how ready are you to cut down?
5.	Negotiate a plan	• What steps can you take to cut down? • Can we schedule a follow-up visit to talk about this?

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Key motivational interviewing techniques

OARS	Open ended questions	Affirmations	Reflections	Summa
REDS	Roll with resistance	Express empathy	Develop Discrepancy	Suppor

Readiness Ruler

Not now 0 1 2 3 4 5 6 7 8 9 10

RUSH UNIVERSITY

SAMHSA

Screen

Women of all ages and Men 65 or older
- in the past year, have you had 4 or more drinks in a day?
- in a typical week, do you have more than 7 drinks?

Men under 65
- in the past year, have you had 5 or more drinks in a day?
- in a typical week, do you have more than 14 drinks?

Women and Men: in the past year, have you used...
- pot, other street drugs or Rx drugs for non-medical reasons?
- drank more then you meant to?
- thought about cutting down on your drinking/drug use?
- been intoxicated when you could hurt yourself/others?

Serving size

Beer 12 OZ | Wine 5 OZ | Liquor 1.5 OZ

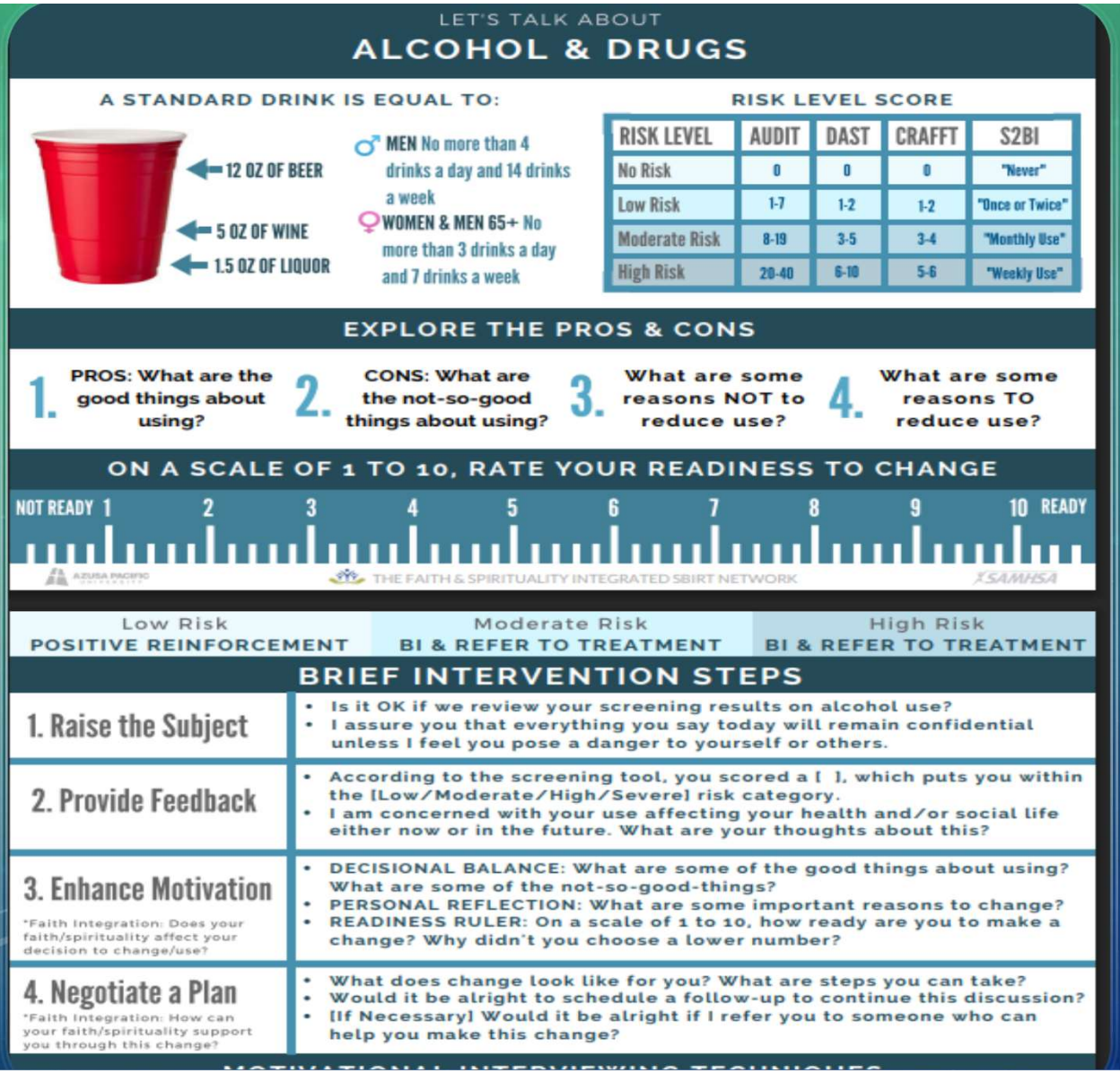
Low Risk Limits	Drinks per day	Drinks per week
All Women	3	7
Men over 65	3	7
Men under 65	4	14

Probable Risk
(actual risk can only be determined by assessment)

Low Risk	No "yes" responses
Moderate Risk	Exceeds daily/weekly limits
Higher Risk	Any of the below: • exceeds daily/weekly limits • drank more than intended • thought of cutting down • intoxicated when could have hurt self or others

Recommended Action

Low Risk	Reinforce
Moderate Risk	Brief Intervention
Higher Risk	Brief Intervention + assess for SUD + consider referral



ANOTHER ONLINE SBIRT POCKET CARD

- https://sbirt.publichealthcloud.com/resources/links/All%20Pocket%20Cards.pdf

WAIT…. THERE'S MORE. IT'S BILLABLE!

Reimbursement for SBIRT

Payer	Code	Description	Fee Schedule
Commercial Insurance	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$33.41
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$65.51
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$29.42
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$57.69
Medicaid	H0049	Alcohol and/or drug screening	$24.00
	H0050	Alcohol and/or drug screening, brief intervention, per 15 minutes	$48.00

FORMAL ASSESSMENT TOOLS & ADHERENCE MONITORING PROCEDURES

- Benefits
  - –Guides individualized care & limits legal liability
- Many formal assessment tools available
- Procedures for Rx adherence monitoring
  - –Short refill intervals
  - – Pill counts
  - – UDT (Urine Drug Testing)
  - – Prescription Monitoring Programs

Examples of Risk Assessment Tools for MISUSE

Acronym	Tool	Purpose of Tool
ABC	Addictions Behavior Checklist (Compton, Wu, Schieffer, & Naliboff, 2008; Wu et al, 2006)	Designed to identify observable behaviors characteristic of addiction related to prescription opioid medications in chronic pain populations during and/or between clinic visits.
CAGE CAGE AID	Cut down, Annoyed, Guilty, Eye-opener for alcohol Adapted to include drugs (Brown & Rounds, 1995)	Quick assessment of level of abuse
DAST	Drug Abuse Screening Test (Skinner, 1982)	28-item self-report screening test that quantifies problems related to drug misuse
COMM	Current opioid misuse measure (Butler, et al., 2007)	Monitoring during chronic opioid therapy
COWS	Clinical Opiate Withdrawal Scale (Wesson & Ling, 2003)	A clinician-administered, pen and paper instrument that rates eleven common opiate withdrawal signs or symptoms
CRAFFT	(Knight et al, 1999)	6 questions for adolescents similar to CAGE asking about drug and alcohol
DIRE	Diagnosis, Intractability, Risks, and Efficacy (Belgrade, Schamber, & Lindgren, 2004)	Quick assessment tool used and filled out by the healthcare provider to determine if they are appropriate for chronic opioid therapy.
DUSI-R	Drug Abuse Screening Inventory (revised) (Tarter & Kirisci, 2001)	Adolescent drug alcohol use, adverse outcomes mental health and lie scale
ORT	Opioid Risk Tool (Webster & Webster, 2005)	For lower risk patients to determine if appropriate for opioid use
PESQ	Personal Experience Screening Questionnaire (Winters, 1992)	Quick questionnaire identifying adolescent drug abuse for referral to substance abuse treatment.
PDUQ	Prescription Drug Use Questionnaire (Compton Darakjian, &Miotto, 1998)	Comprehensive for addiction or problematic drug use
POSIT	Problem Oriented Screening Instrument for Teenagers (Latimer, Winters, & Stinchfield, 1997)	Assessment of adolescent drug abuse
SOAPP	Screener and Opioid Assessment for Persons in Pain (Butler, Budman, Fernandez, & Jamison, 2004)	For higher risk patients Appropriateness for opioid therapy or misuse
TICS	Two-Item Conjoint Screen (Brown, Leonard, Saunders, Papasouliotis, 2001)	A two-item conjoint screen for alcohol and other drug abuse or dependence

(e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

In the past 12 months...		Circle	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop abusing drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.		**Score:**	

Interpretation of Score		
Score	**Degree of Problems Related to Drug Abuse**	**Suggested Action**
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Drug Abuse Screening Test (DAST-10). (Copyright 1982 by the Addiction Research Foundation.)

DAST-10 TOOL

- Measures "involvement" with drugs (excludes ETOH) and degree of risk.
- NOT the same as OUD

OPIOID RISK TOOL (ORT)

Scoring;

- 0-3 = low risk for opioid misuse
- 4-7= mod risk for misuse
- 8 or more = high risk for misuse

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

NIH National Institute on Drug Abuse

OPIOID RISK TOOL- OUD (ORT-OUD)

Scoring;

- 0-2= low risk for OUD
- 3 or more = high risk for OUD

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		

Back to To

RECOMMENDED READING ON PAIN & SUD

ASPMN & IntSNA Manuscript

Turner, H. N. et al. (2022). Pain management and risks associated with substance use: Practice recommendations. *Pain Management Nursing,* 23, 91-108. doi.org/10.1016/j.pmn.2021.11.002

Pain Management Nursing 23 (2022) 91–108

Contents lists available at ScienceDirect

Pain Management Nursing

journal homepage: www.painmanagementnursing.org

Pain Management and Risks Associated With Substance Use: Practice Recommendations

Helen N. Turner, D.N.P., P.C.N.S.-B.C., P.M.G.T.-B.C., A.P.-P.M.N., F.A.A.N.[a], June Oliver, M.S.N., A.P.R.N./C.N.S., C.C.N.S., P.M.G.T.-B.C., A.P.-P.M.N.[b,1], Peggy Compton, R.N., PhD, F.A.A.N.[c], Deborah Matteliano, Ph.D., F.N.P.-B.C.[d], Timothy Joseph Sowicz, Ph.D., N.P.-C.[e], Stephen Strobbe, Ph.D., R.N., P.M.H.C.N.S.-B.C., C.A.R.N.-A.P., F.I.A.A.N., F.A.A.N.[f], Barbara St. Marie, Ph.D., A.G.P.C.N.P., P.M.G.T.-B.C., F.A.A.N.P., F.A.A.N.[g], Marian Wilson, Ph.D., M.P.H., R.N., P.M.G.T.-B.C.[a,h]

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ARTICLE INFO

Article history:
Received 4 November 2021
Accepted 13 November 2021

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.

SUMMARY :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 and nonpharm analgesia
7. Continual eval 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

Turner, H. N. et al. (2022).

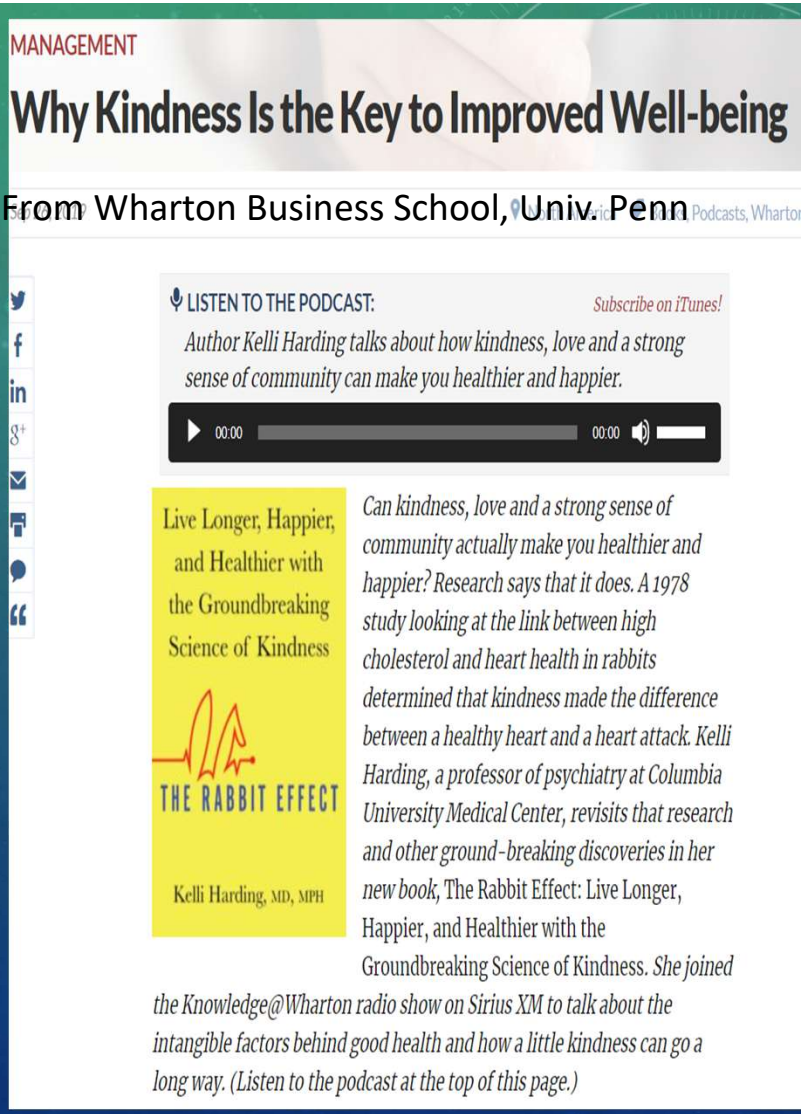
CURIOSITY & LISTENING

- Initiate conversation with patients w/ SUD history/risk
  - Approach w/ curiosity & compassion
  - " I'm interested in your history with substances if you are able to share that with me. It helps me know how to best help you".
  - Facts; start, routes, # substances, sober periods, past rehab
  - Personal story: why start, why continue, what benefit did you get, concurrent stressors, negative consequences
  - Ask re: readiness for change/ receiving help
- Helps humanize the patient
- Enhances compassion & appropriate cautions
- Builds trust/ therapeutic relationship
- Helps patient recovery/healing

BUILD A RELATIONSHIP…

(THE RABBIT EFFECT BY KELLI HARDING, M.D., MPH)

- 10-20% overall health r/t quality of healthcare
- Biggest health impact = relationships
- Science of epigenetics and telomere research
  - loving actions actually change physiology.
- Loneliness = health risk same as smoking 15 cigarettes/day, heavy alcohol use, HTN, obesity
- Your nurse-pt relationship can matter!!



MANAGEMENT

Why Kindness Is the Key to Improved Well-being

From Wharton Business School, Univ. Penn

LISTEN TO THE PODCAST: Subscribe on iTunes!

Author Kelli Harding talks about how kindness, love and a strong sense of community can make you healthier and happier.

00:00 00:00

Live Longer, Happier, and Healthier with the Groundbreaking Science of Kindness

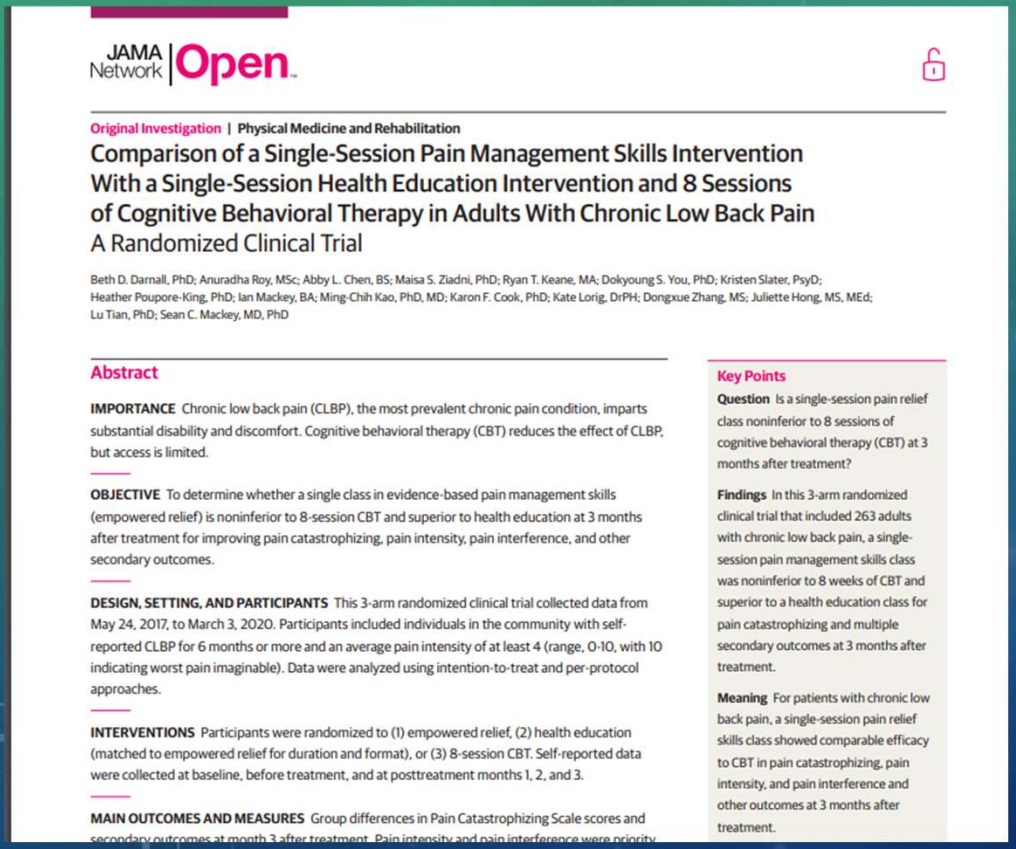
THE RABBIT EFFECT

Kelli Harding, MD, MPH

Can kindness, love and a strong sense of community actually make you healthier and happier? Research says that it does. A 1978 study looking at the link between high cholesterol and heart health in rabbits determined that kindness made the difference between a healthy heart and a heart attack. Kelli Harding, a professor of psychiatry at Columbia University Medical Center, revisits that research and other ground-breaking discoveries in her new book, The Rabbit Effect: Live Longer, Happier, and Healthier with the Groundbreaking Science of Kindness. *She joined the Knowledge@Wharton radio show on Sirius XM to talk about the intangible factors behind good health and how a little kindness can go a long way. (Listen to the podcast at the top of this page.)*

Why Kindness Is the Key to Improved Well-being - Knowledge@Wharton (upenn.edu)

EMPOWERED RELIEF FOR CHRONIC PAIN: RETRAIN THE BRAIN



JAMA Network | Open

Original Investigation | Physical Medicine and Rehabilitation

Comparison of a Single-Session Pain Management Skills Intervention With a Single-Session Health Education Intervention and 8 Sessions of Cognitive Behavioral Therapy in Adults With Chronic Low Back Pain
A Randomized Clinical Trial

Beth D. Darnall, PhD; Anuradha Roy, MSc; Abby L. Chen, BS; Maisa S. Ziadni, PhD; Ryan T. Keane, MA; Dokyoung S. You, PhD; Kristen Slater, PsyD; Heather Poupore-King, PhD; Ian Mackey, BA; Ming-Chih Kao, PhD, MD; Karon F. Cook, PhD; Kate Lorig, DrPH; Dongxue Zhang, MS; Juliette Hong, MS, MEd; Lu Tian, PhD; Sean C. Mackey, MD, PhD

Abstract

IMPORTANCE Chronic low back pain (CLBP), the most prevalent chronic pain condition, imparts substantial disability and discomfort. Cognitive behavioral therapy (CBT) reduces the effect of CLBP, but access is limited.

OBJECTIVE To determine whether a single class in evidence-based pain management skills (empowered relief) is noninferior to 8-session CBT and superior to health education at 3 months after treatment for improving pain catastrophizing, pain intensity, pain interference, and other secondary outcomes.

DESIGN, SETTING, AND PARTICIPANTS This 3-arm randomized clinical trial collected data from May 24, 2017, to March 3, 2020. Participants included individuals in the community with self-reported CLBP for 6 months or more and an average pain intensity of at least 4 (range, 0-10, with 10 indicating worst pain imaginable). Data were analyzed using intention-to-treat and per-protocol approaches.

INTERVENTIONS Participants were randomized to (1) empowered relief, (2) health education (matched to empowered relief for duration and format), or (3) 8-session CBT. Self-reported data were collected at baseline, before treatment, and at posttreatment months 1, 2, and 3.

MAIN OUTCOMES AND MEASURES Group differences in Pain Catastrophizing Scale scores and secondary outcomes at month 3 after treatment. Pain intensity and pain interference were priority

Key Points

Question Is a single-session pain relief class noninferior to 8 sessions of cognitive behavioral therapy (CBT) at 3 months after treatment?

Findings In this 3-arm randomized clinical trial that included 263 adults with chronic low back pain, a single-session pain management skills class was noninferior to 8 weeks of CBT and superior to a health education class for pain catastrophizing and multiple secondary outcomes at 3 months after treatment.

Meaning For patients with chronic low back pain, a single-session pain relief skills class showed comparable efficacy to CBT in pain catastrophizing, pain intensity, and pain interference and other outcomes at 3 months after treatment.

- Single session class via Endeavor Health Psych
- Pain Management skills
- Certified instructors- any discipline
- As good as 8 weeks CBT : better than health education class
- Reduced
  - pain catastrophizing
  - sleep disturbance
  - pain bothersomeness
  - pain behavior
  - Depression & anxiety
- Enrollment at https://empoweredrelief.stanford.edu/

RESOURCES FOR PAIN & SUD:

www.aspmn.org

- **ASPMN® Position Statements** – Position statements are recommendations for a course of action or statement of beliefs that reflects ASPMN®'s stance regarding an issue of importance to safe practice, safe care and optimal patient outcomes.
  - Authorized Agent Controlled Analgesia – *(Revised: August 2024)*
  - Deceptive Use of Placebos in the Assessment and Management of Pain *(Revised July 2021)*
  - Disparities, Inequities, and Injustices in Populations with Pain: An ASPMN Position Statement (April 2025)
  - Male Infant Circumcision Pain M*(Revised July 2021)*
  - Monitoring for Opioid-Induced
  - Pain Assessment in the Patient
  - Prescribing and Administering
    Society for Pain Management N
  - Procedural Pain Management F
  - Range Orders in the Management of Pain (Revised November 2023)
  - Registered Nurse Management and Monitoring of Analgesia By Catheter Techniques *(Revised 2023)*

- **ASPMN® Joint Statements** – Joint position statements are an assertion of the beliefs held, encouraged and supported but written in collaboration with other external organizations with mutual interest.
  - Pain Management at the End of Life - This is a joint position statement from: American Society for Pain Management Nursing® and Hospice and Palliative Care Nurses Association *(Revised: 2024)*
  - Pain Management and Substance Use Disorders – This is a joint statement from: American Society for Pain Management Nursing® and International Nurses Society on Addi*(Revised: 2022)*

- **ASPMN® Guidelines** - Recommendations to provide information to optimize health interventions (clinical, public health, or policy); clinical practice guidelines include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of benefits and harms of alternative care options.
  - Guidelines on Monitoring for Opioid-Induced Sedation and Respiratory Depression: Revisions *(Approved June 2019)*

- **ASPMN® Supported Statements** – Supported position statements are statements written by an external organization with content expertise identifying a course of action or statement of belief. These statements are officially supported by ASPMN®
  - ANA The Ethical Responsibility to Manage Pain and the Suffering It Causes

PAIN & SUD TAKE-HOME MESSAGES

PAIN

- Treat the cause aggressively
- Maximize non-opioid Rx & interventions
- Judicious Opioid Use
  - Preferred short-term for mod/severe pain
  - Adherence Monitoring

SUD RISK

- Screen routinely; recognize risk; refer for mental health support
- Monitor adherence
  - Pill counts, ILPMP, UDTs
  - Universal Precautions
- Treat acute pain aggressively
  - Severe, unmanaged pain raises relapse risk
  - May need higher opioid doses acutely
  - Consider ketamine to lower tolerance/aid w/ neuropathic pain)
  - PCA may be considered;
  - maximize non-opioid analgesia
  - Refer for SUD treatment; do not discontinue care

PAIN & SUD INTERSECTION : REVIEW

Thorough pain etiology workup

- Don't automatically dismiss complaints r/t comorbid psych/SUD issues

Treat the pain;

Manage Acute pain well

Multimodal, procedures

Evaluate SUD/misuse risk

- Distinguish between aberrant behavior and OUD
- Use the right assessment tool

Adherence Monitoring

- Educate NMPR
- UDT, pill counts, Treatment Agreement ,short refills

Interdisiplinary Team/Referrals

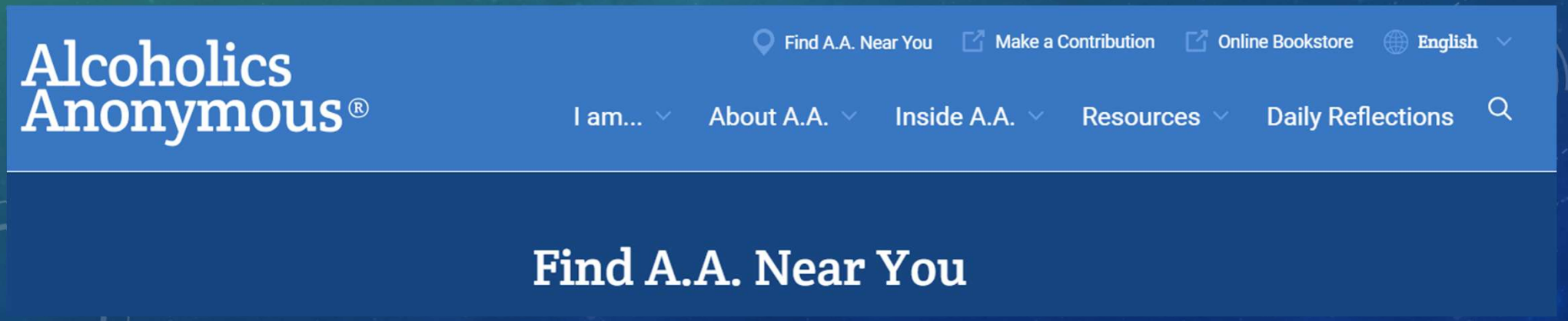
- Psychology, psychiatry, Addiction Medicine
- Methadone/Buprenorphine

Don't Abandon Patient

- Restrict home opioids if needed for safety;
- Enhance wholistic analgesia
- Therapeutic Relationship

TO UNDERSTAND MORE FROM A PATIENT VIEWPOINT……

- Visit an “open” AA or NA meeting
  - Hear recovery stories
- Humanizes patients struggling w/ SUD
  - Build rapport/therapeutic relationship
- Inspires vision of recovery
  - Guards against cynicism or hopelessness



FOLLOW YOUR PASSION…..

IT WILL LEAD YOU TO YOUR PURPOSE

Every Nurse is a Pain Management Nurse!

….ASPMN….

QUESTIONS/COMMENTS?

EMAIL: JEGO1RN@GMAIL.COM

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