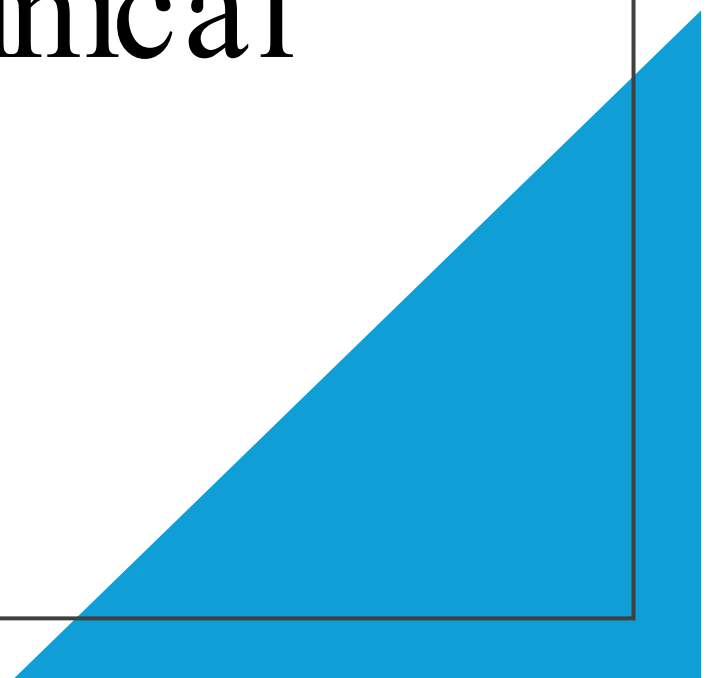


"When Pain Threatens Recovery: Chronic Pain, Opioids, and Emerging Clinical Concerns."

Barbara St. Marie, PhD, AGPCNP

Associate Professor Emeritus

University of Iowa



Outline

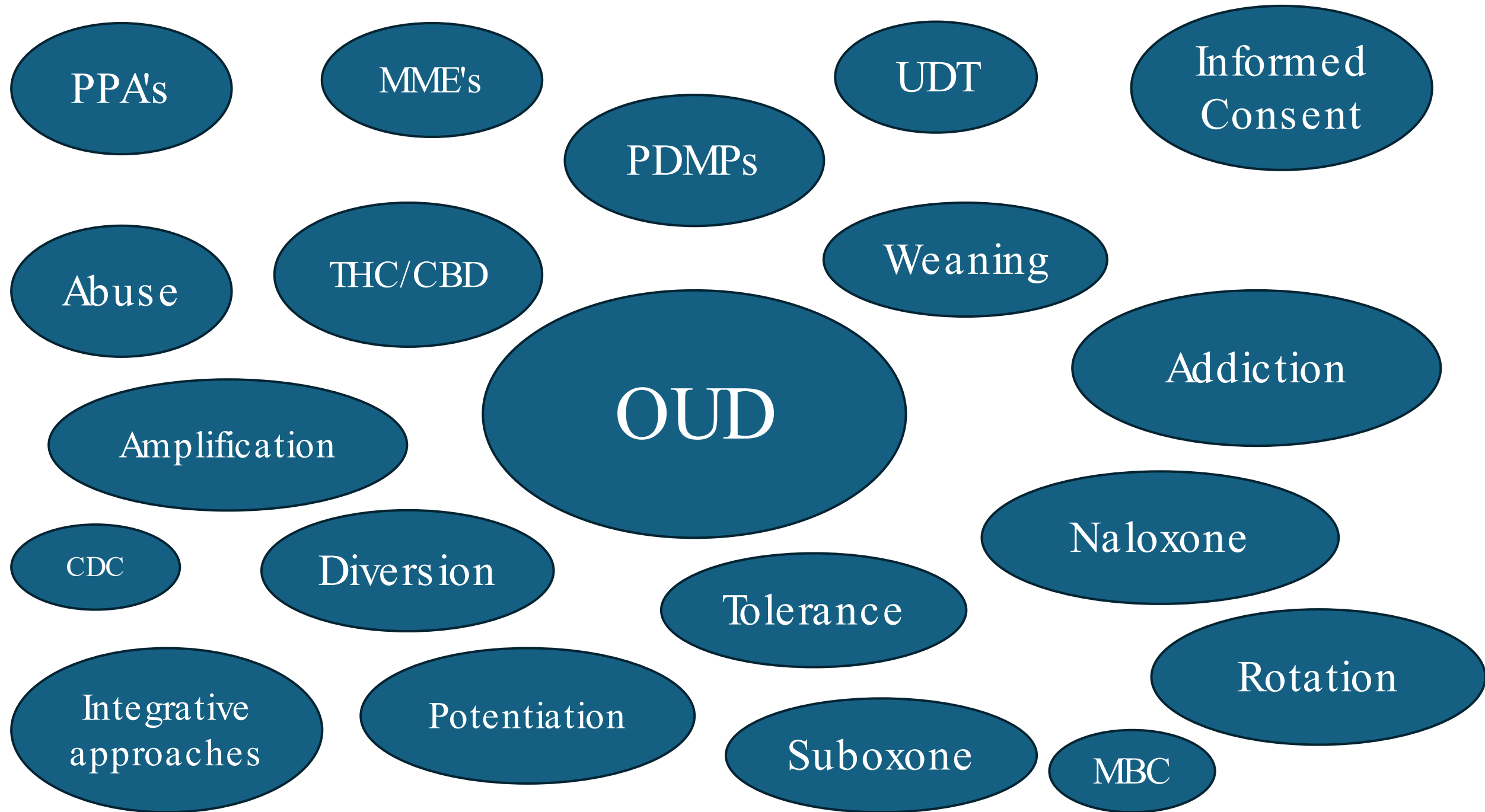
- Biology of the intersection of pain and addiction
- Differentiating pain-management behaviors from substance misuse
- Working with clients who experience both chronic pain and opioid-use disorder
- Addressing stigma toward individuals receiving pain medication
- Improving communication among counselors, prescribers and clients
- Supporting relapse prevention when pain remains unresolved

Objectives

- Describe the pathophysiology of pain
- Accurately assess patients with pain
- Recognize behaviors that may be associated with opioid use disorder
- Identify evidence-based non-opioid options for treatment of pain

Additional Goals or Questions

- What is currently of most interest to you concerning pain management and opioids prescribed?
- Think about your patients and what “keeps you up at night”!
- Identify one or two things you hope to take away that would assist you in being a better healthcare professional.
- How can you keep your patient safe?



Devon

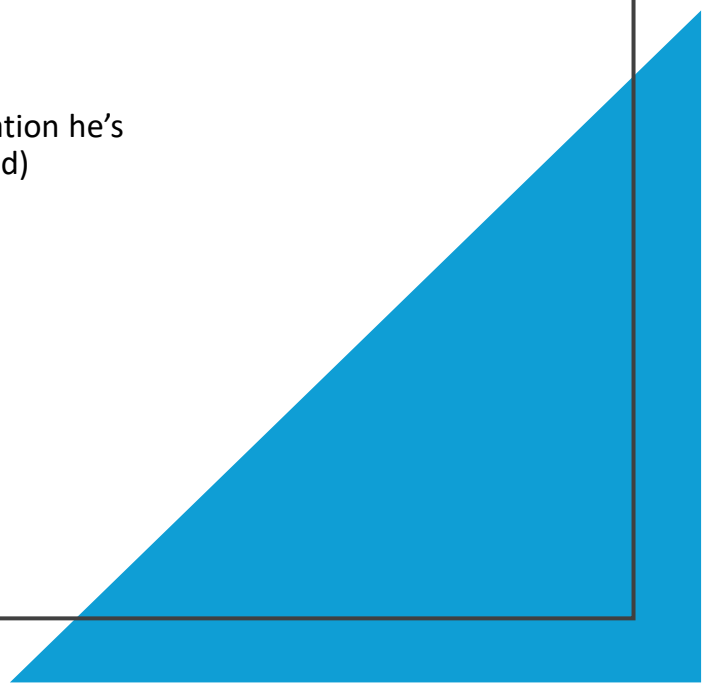
- 40-years-old, moved to the area for a new job post-military service, and has been referred to team
- Presents with complaint of continuing chronic hip pain and needs opioid refill.





What causes
his pain?

Factors

- Issues: Pt moved in from out of state – you are unable to access prescription drug monitoring programs (PDMP) from out of state (also, addiction clinics may not reveal or military facilities operate their own PDMP).
 - Requests refill of opioids (narcotics) while you talk with him. Talk with prescriber about: a) what medication he's tried: acetaminophen, NSAID's, b) tried PT and it didn't help, c) had a steroid injection without benefit, d) quantity to give?
 - Are there any clinical tools you can use to help assess his risk for taking opioids?
 - When would you have him follow up?
- 

Opioid Risk Tool – OUD (ORT-OUD)

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

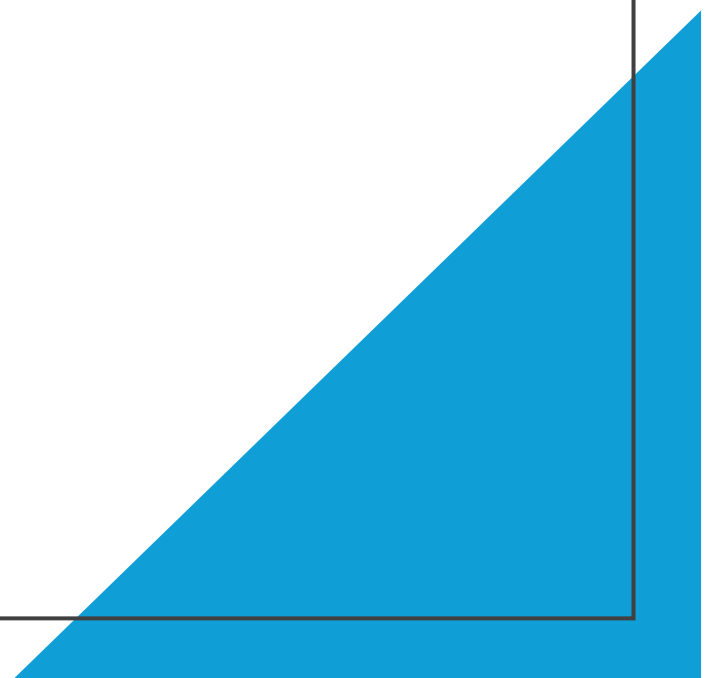
Mark each box that applies	YES	NO
Family history of substance abuse		
Alcohol	1	0
Illegal drugs	1	0
Rx drugs	1	0
Personal history of substance abuse		
Alcohol	1	0
Illegal drugs	1	0
Rx drugs	1	0
Age between 16–45 years	1	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	1	0
Depression	1	0
Scoring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

Opioid Risk Tool (ORT-OUD) for Risk Screening

- Substance use disorder history does not prohibit treatment with opioids but may require additional monitoring and expert consultation or referral.
- Scoring:
 - ≤ 2 : low risk
 - ≥ 3 : high risk

Other tools to assess risk

- SBIRT
 - Screening, Brief Intervention, and Referral to Treatment
- TAPS
 - Tobacco, alcohol, prescription, and other substances
- PDUQ
 - Prescription Drug Use Questionnaire
- PMQ
 - Pain Medication Questionnaire
- COMM
 - Current Opioid Misuse Measure

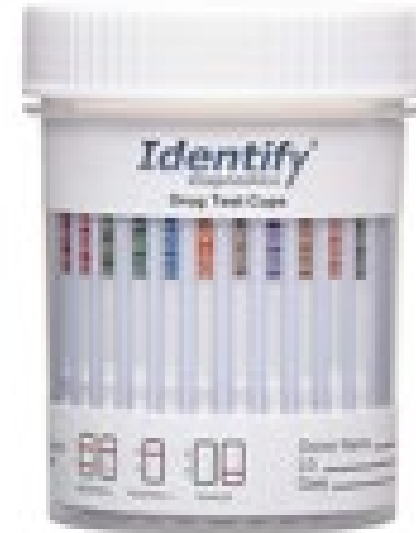


Actions

- Urine drug testing
- Obtain outside records – consider giving a small amounts of meds until next visit and records are reviewed
- Patient- Provider Agreement Form
- Follow up schedule

Urine Drug Testing (UDT)

- Urine testing is done FOR the patient, not TO the patient
- Helps to identify drug misuse/addiction
- Assists in assessing and documenting adherence
- Clinical considerations
 - Recommend UDT before first prescription, then intermittently, depending on clinical judgment and state regulations
 - Document time and date of last dose taken
 - Be aware of possible false positives or negatives
 - Clarify unexpected results with the lab before confronting patient to rule out poor specimen or error



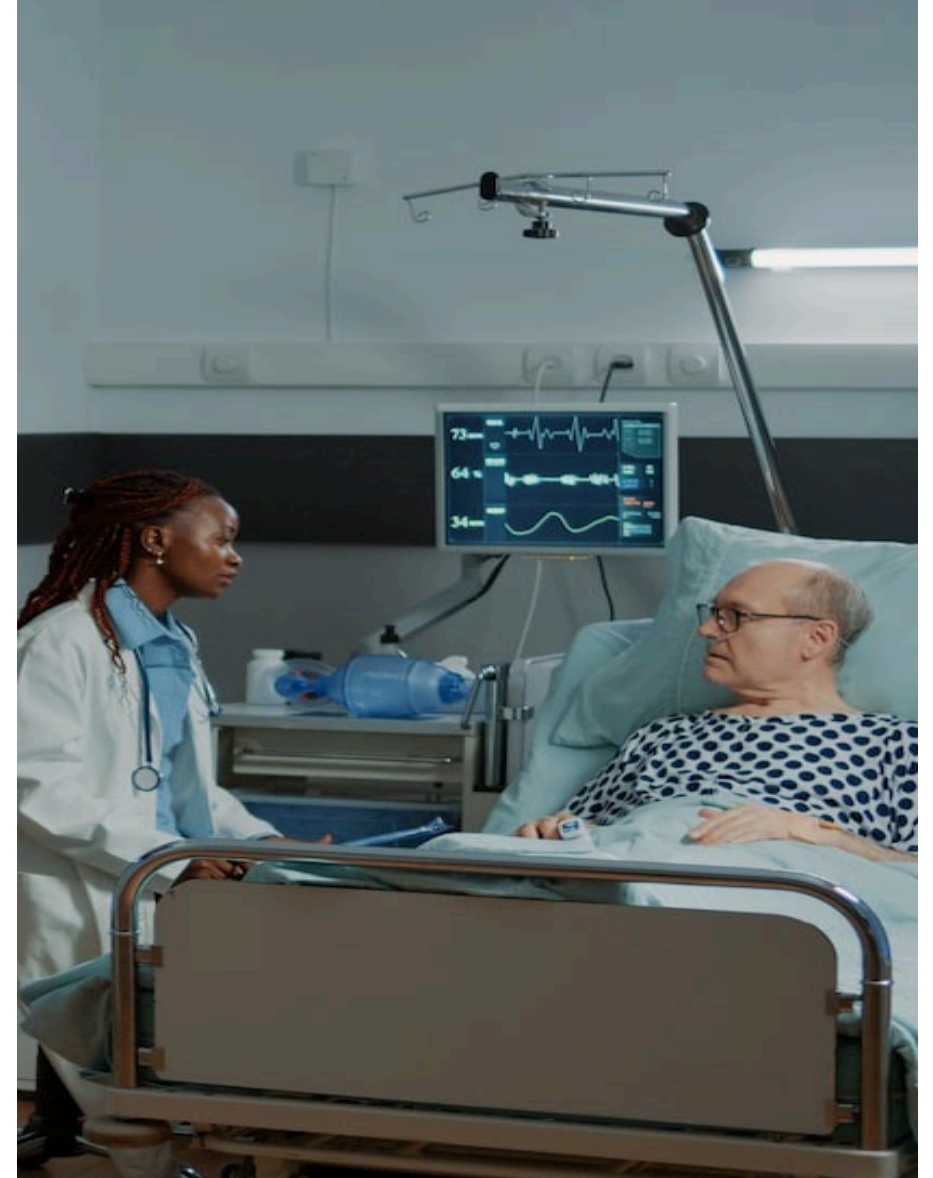
Patient Provider Agreement (PPA)

Reinforce expectations for appropriate and safe opioid use

- One prescriber
- Consider one pharmacy
- Safeguard
 - Do not store in medicine cabinet
 - Keep locked (medication safe)
 - Do not share or sell
- Instructions for disposal when no longer needed
- Prescriber notification for any event resulting in a pain medication prescription
- Follow-up
- Monitoring
 - Random UDT and pill counts
- Refills
- Identify behaviors for discontinuation
- Exit strategy

Burt with his healthcare provider

- 70 yo male with remote hx of alcohol dependence, chronic pain with ? opioid abuse, stage 4 prostate cancer who stopped treatment due to untreated pain.
- Requests high dose opioids which oncologist will not prescribe
- Meds: was on methadone 60 mg/day but changed to hydrocodone 30 mg/day. Dose not helping with pain.
- How would you proceed?

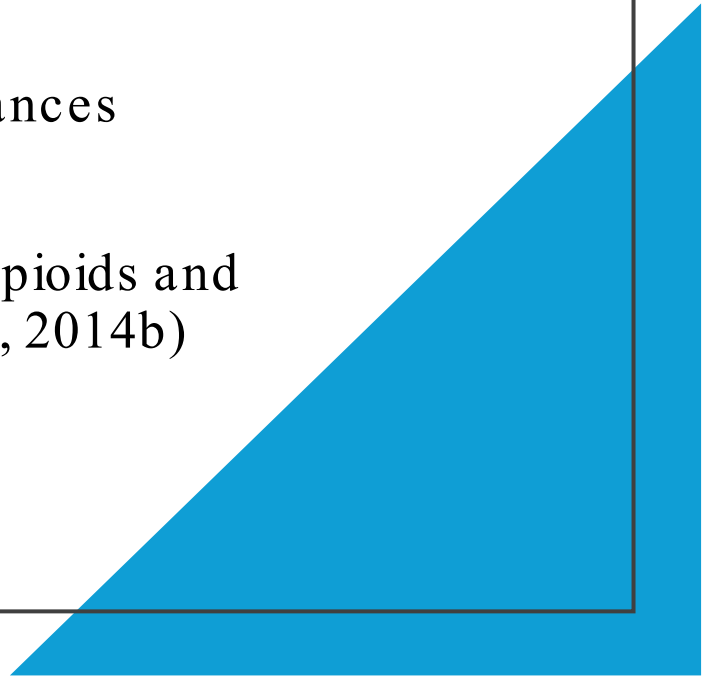


Methadone Clinic Study Group A: When Addiction Appears First

- Introduced by friends
- Pain Rx incorporated into drugs of abuse
- Escalated dose
- Males: crime and episodic incarceration
- Females: domination by males, sex work, stealing
- Violence, injuries or illness
 - resulted from substance use
 - lead to further pain and suffering
- When pain became part of their lives, addictions became worse. (St. Marie, 2014a)

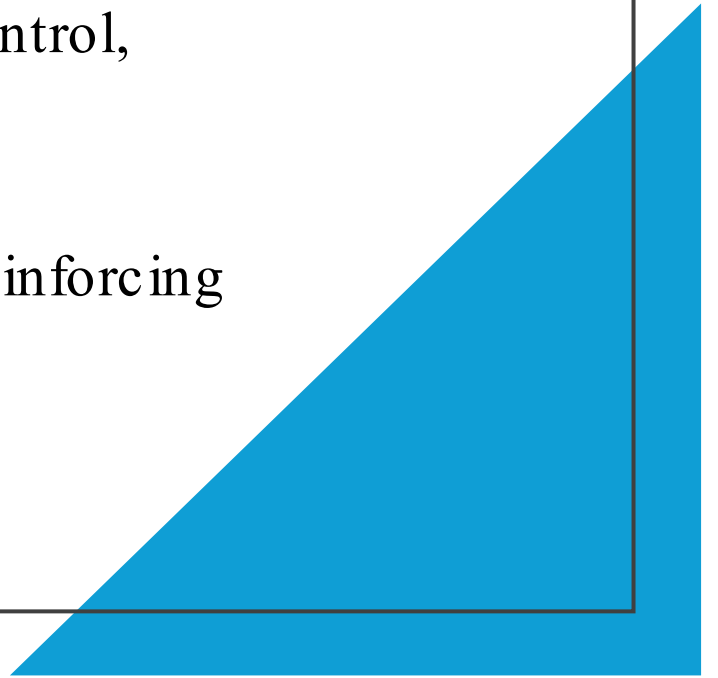
Methadone Clinic Study Group B: When Pain Appears First

- Health care providers: initial exposure (100%)
- Abusing prescription opioids
- Transitioned to illicit substances
- Abused both prescription opioids and illicit substances (St. Marie, 2014b)



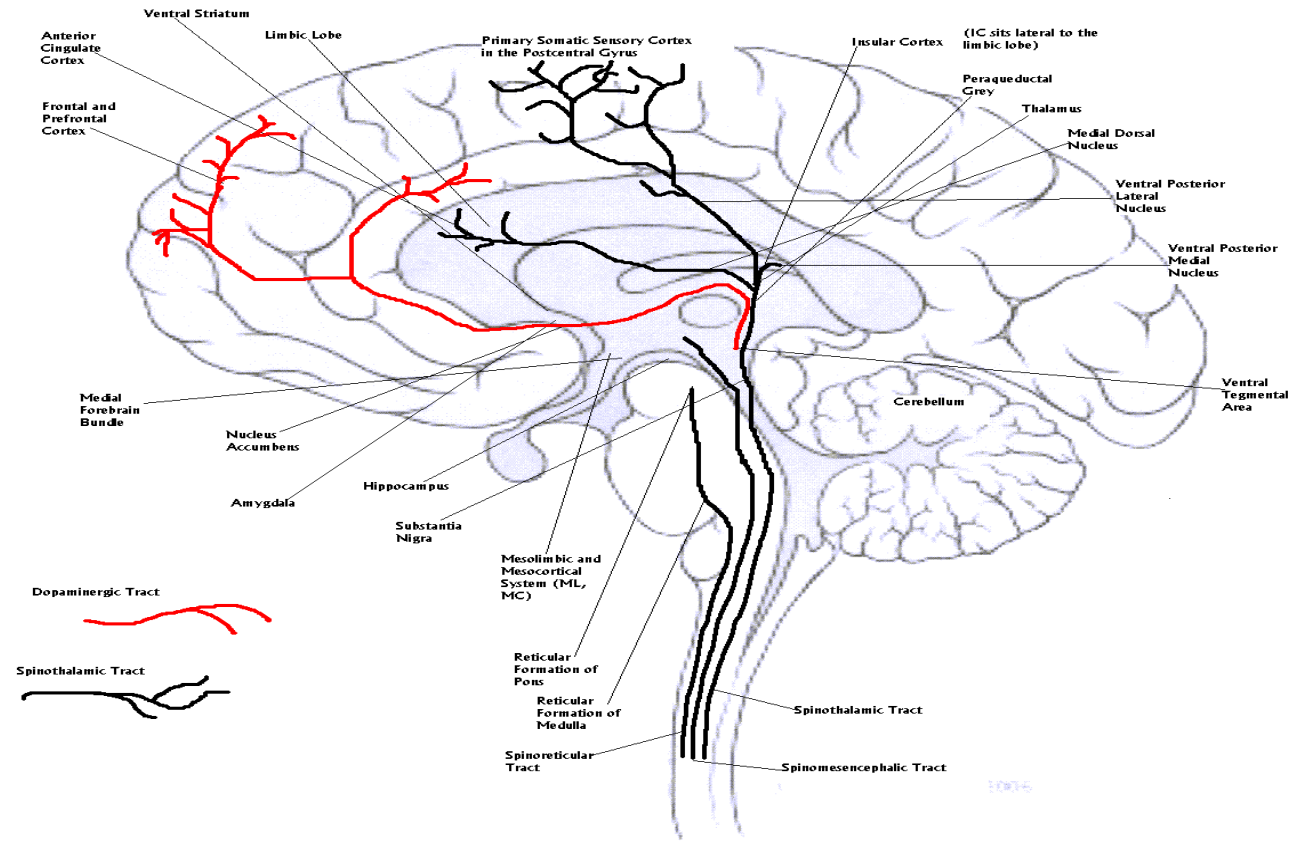
The “Double Whammy”

- When addiction was out of control, pain was worse
- When pain was out of control, addiction was worse.
- Each caused mutually reinforcing cascade



Common experiences for both groups

- Procurement of prescription opioids from HCP
 - No gender differences
- Behaviors were activated and intensified
 - Deception
 - Creating injuries or fake allergies
 - Claiming opioids as stolen
 - Refusing other therapies used to treat pain
 - Bringing in radiological films as proof to pain



Opioid Use Disorder: DSM-5-TR Criteria

Be alert to these factors in your patient on long-term opioid therapy

Taking larger amounts and/or for longer periods than intended

Persistent desire or inability to cut down or control use

Increased time spent obtaining, using, or recovering

Craving/compulsion to use opioids

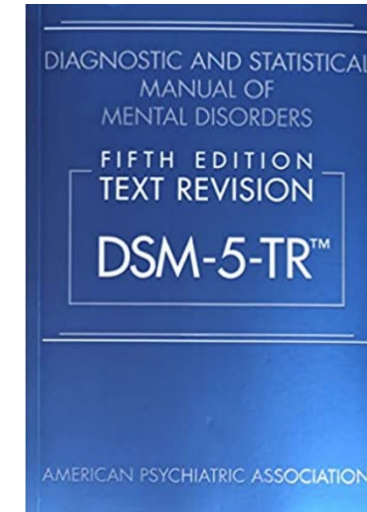
Role failure at work, home, school

Social or interpersonal problems

Reducing social, work, recreational activity

Physical hazards

Physical or psychological harm



Tolerance

Withdrawal

Scoring:

2-3 = mild

4-5 = moderate

≥6 = severe

“One word frees us of all the weight and pain of life: That word is love.”

Sophocles (496BC – 406BC)



Characteristics of early, intense romantic love

Euphoria and energy

Intense focused attention

Obsessive thinking

Emotional dependency and craving

With person – feel great

Not with person – obsessive thoughts of person
and can't wait until see person again



Sophia

- 26 yo pregnant female with chronic low back pain.
- Past MVA
- Many physicians and no one will help.
- Now with pregnancy, pelvic pain
- Self medicated with illegally obtained opioids
- Takes oxycodone/APAP 5/325mg 6-10 tabs daily
- How do you approach managing her pain?



Stigma...

Stigma towards people with OUD manifests with discriminatory behaviors: stereotyping and labelling

- Health care professionals show stigmatizing attitudes
 - 20-51% endorse moral or spiritual models of addiction that blame the person (Cazalis et al., 2023)
 - Stigma prevent patients and families from seeking treatment, and can result in relapse (Hayek et al., 2024)
- System-related stigma is manifested in...
 - Insufficient prevention services
 - Unequal access to health-care services, poor screening
 - Inadequate skill sets and knowledge deficiencies among health care team (Mackiewicz et al., 2025; Rehman et al., 2024; Parish et al., 2025)

Experiences with Health Care

- Stigma
 - “Tears me apart” (Bill)
 - Felt like he wanted to use again (Franklin)
 - Stereotyped: “drug seeking”, “pill seeking”
 - Some did not want to keep their addiction a secret
 - Discrimination (i.e. ED)
 - Not feeling well cared for (St. Marie, 2014a)

Experiences with Health Care Team

- Over prescribing
 - Large volumes
 - High doses
 - Little to no monitoring
 - No other interventions offered (St. Marie, 2014a)

Miles

- 25 yo underwent rehab in jail and is now in recovery
- Presents with work-related low back injury
- Wants NO opioids or other prescription pills
- What alternatives can you offer?



Theme From Primary Care Study: Protecting sobriety

- “Won’t use heroin because I’m more scared of that than anything, you know what I’m saying?” (participant #6)
- “I don’t wanna screw up my sobriety. I don’t wanna get addicted. I was very frightened about getting addicted and frightened about craving [from prescription opioids for pain]” (participant #2)

Theme From
Primary Care
Study:
Non-medicine
ways of
managing pain

- Background noise
- Walking dogs
- Change of diet
- Exercise and stretching, physical therapy
- Healthy mind – counseling, meditation
- Fishing
- Developed protocol for medication taking
- Massage

Karen

- 65 yo female new to clinic, pain from spinal stenosis, tobacco use disorder (20 pack-year history), COPD, and panic disorder
- Meds: Alprazolam 1mg TID, oxycodone 5 mg TID, Tiotropium inhaler
- Requests refill of all her meds, says, “My usual doctor refused to prescribe for me anymore.”



Challenges to Health Care Providers

- Ambiguity of how to manage patients with coexisting addiction and pain conditions
 - Time consuming
 - Low success rate
 - Undertreating vs over prescribing opioids
- Goal: Managing pain without furthering misuse or addiction

(Berg, et al., 2009; Upshur, et al., 2006; Wilsey, et al., 2008; Baldacchino, et al., 2010)

Challenges in Primary Care

- Barriers of providers in chronic pain management
 - Absence of objective or physiological measures of pain
 - Spinal stenosis?
 - Lack of expertise in pain and addiction
 - Colleague issues
 - Coverage for each other breaks down at times
 - Limited insurance coverage for everything except opioids

(Barry, et al., 2010)



What do our
Patients Tell Us !!

+

•

○

Challenges for Patients

- Addiction
 - “Nobody wants to grow up to become a drug addict” (St. Marie, 2014)
- Stigma
- Pain not well treated
 - (Campbell & Cramb, 2007; Trafton, et al., 2004)



Complications of coexistence: Pain and Addiction



- Chronic pain and addiction coexist
 - Health complications above and beyond their pain and addiction.
 - more psychiatric disturbances
 - higher utilization of health care services
 - lower quality of life
 - less social support
 - **Understand the person's experiences with escalating anxiety, depression, and seeking out drugs, compounded by their desperation in dealing with pain.**
- 

Patients' Perspective on Providers

- Prescriber and participant unprepared for this
 - Potentially life threatening
 - This situation should be given the same level of intensity of health care as their initial injury
 - Prescriber: assume responsibility for OD, rather than just “blame the victim”

Patients' Perspective on Providers

- Confidence in health care team (50%)
 - Treating both addiction and pain
- “Just because I’m an addict doesn’t mean I don’t have pain” (phrase used by many participants)
- Best Outcome
 - “I’ve really great doctors that I’m working with now that understand my addiction and understand that I do need to control my pain.” (Helene)
 - Supportive and caring relationship
 - Open and honest communication
 - Pain treatment

Voice of the Participants

- Regarding receiving prescription opioids for treatment of pain, even while on methadone:

“I mean it might trigger relapse if I have a whole bunch of pills in my hand. Say I have 30 pills yeah, I might think about taking five, six of ‘em. I’m an addict, it’s in our minds.” (Cindy)

Participants' recommendations to prevent prescription opioid abuse

- “It’s the same pills you help me with that hurt me.” (Dennis)
 - Higher level opioids
 - Reduce opioids in steps
 - Watch pain reduce
 - Non-addictive analgesics
 - Acupuncture
 - Six days
 - Relationship
 - Support sobriety

Quotes from Primary Care Study

- “What makes me mad is just because a person was an addict – it was so hard just to find a doctor to help me with pain”(Participant #7)
- All participants felt they were mis-treated by physician in primary care or emergency room at one time or another.
- “If I’m not getting it from my doctor then I gotta find other ways to get it.”(Participant #3)

Conclusions from studying the human experience

- We understand patient experiences
 - Initiation of pain from SUD behaviors
 - Initiation of SUD following pain treatment (opioids)
 - Mutually reinforcing cascade
 - Cycle of pain, SUD, healthcare, entry at any point
 - Supports and stresses
 - Some are helped by opioids for pain, some are hurt.
 - Importance of HCP helping people protect sobriety

Conclusions from studying the human experience

- Participant's use of deception to obtain opioids
 - Meant drug cravings were out of control
- Health care providers
 - Little understanding or ability to help chronic pain
- Participants who abuse opiates again
 - Receive less care, poor treatment by the health care team,
- Positive health care = help maintain sobriety
 - Instill confidence and caring

Keys to Improving Communication among Healthcare Teams

- Goal: Avoid conflicting messages to the patient.
- Care Coordinator: Serve as a central point of contact and ensure all team members have same information.
- Create an integrated care team
 - Primary Care, Pain management specialists, Addiction medicine specialists, Mental health professionals, Pharmacists, Social Workers/case managers, Physical and occupational therapists
 - Define team members' roles and responsibilities.

Key Communication Strategies (cont.)

- Standardized Communication Process
 - Implement structured communication tools
 - SBAR (Situation, Background, Assessment, Recommendation)
 - Standardized handoff templates
 - Shared consultation notes
 - Regular progress updates
- Consistency helps prevent important information from being overlooked.

Key Communication Strategies

- Develop a Shared Care Plan
 - All team members can access and update
 - Reduces conflicting recommendations and provides consistent message to patient
- Shared Care Plan Includes
 - Pain diagnosis and treatment goals
 - SUD treatment goals
 - Medication list and prescribing responsibilities
 - Non-pharmacologic interventions
 - Risk mitigation strategies
 - Emergency and relapse plans

Key Communication Strategies (cont.)

- Hold Regular Case Conferences
 - Schedule recurring interdisciplinary meetings
 - Brief monthly or biweekly case reviews can significantly improve care coordination
- Topics may include
 - Changes in pain symptoms
 - Recovery progress
 - Medication concerns
 - Behavioral health needs
 - Social determinants affecting care

Key Communication Strategies (cont.)

- Leverage Electronic Health Records (EHRs)
 - Real-time access to information minimizes delays and miscommunication
- Optimize EHR to
 - Share treatment plans across disciplines
 - Flag high-risk medications
 - Document opioid agreements
 - Track urine drug screening results when appropriate
 - Provide secure messaging among team members

Key Communication Strategies (cont.)

- Include the Patient and Family
 - Patient is the active participant in communication
 - When patients understand the plan, adherence, and outcomes often improve
- Shared decision-making
 - Written care summaries
 - Family involvement when appropriate and consented
 - Patient portals for accessing care plans and appointments

Key Communication Strategies (cont.)

- Address Behavioral Health and Social Needs
 - Housing instability
 - Transportation barriers
 - Employment concerns
 - Mental health symptoms
 - Community support Services
- Track Metrics
 - Hospital readmissions
 - ED utilization
 - Patient (and separately Provider) satisfaction
 - Treatment adherence

1



Primary care identifies a patient
with chronic pain and opioid use disorder.



2



A care coordinator schedules a
multidisciplinary review.



3



The team creates a
unified treatment plan.



4



Pain, addiction, and behavioral health providers
document in a shared record.



5



Monthly case conferences review
progress and adjust treatment.



6



The patient receives one consistent set of
recommendations from all team members.



Supporting Relapse Prevention when Pain Remains Unresolved

- Validate Pain
 - “I believe your pain is real.”
 - “We can work on managing pain and supporting recovery at the same time.”
- Validation reduces:
 - Frustration
 - Hopelessness
 - Disengagement from treatment
- Avoid:
 - “Pain is all the experience of Addiction”
 - “Pain is just psychological”

Supporting Relapse Prevention when Pain Remains Unresolved

- Identify Relapse Triggers Related to Pain
 - Ask: “When your pain gets worse, what thoughts or urges do you notice?”
- Help patient recognize and track:
 - Pain flare-ups -- defined: “Same pain, same location, greater intensity”
 - Poor sleep
 - Reduced function
 - Stress and anxiety
 - Feelings of helplessness
 - Social isolation
 - Track function not just pain scores

Supporting Relapse Prevention when Pain Remains Unresolved

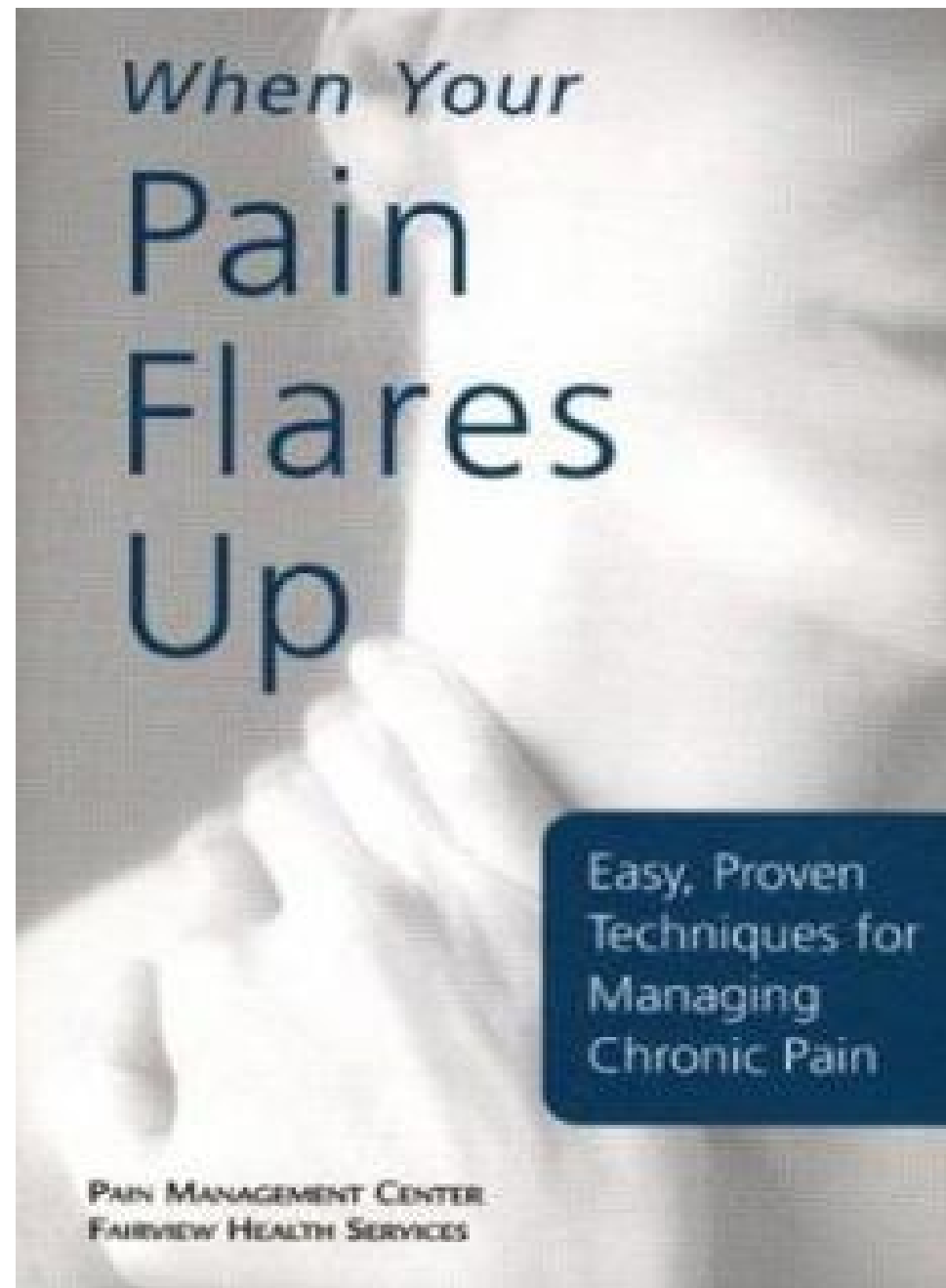
- Increase Support During High-Risk Periods
 - When pain worsens:
 - More frequent visits
 - Care coordinator check-ins
 - Behavioral health appointments
 - Recovery support meetings
 - Peer recovery coaching
- Address Catastrophic Thinking
 - Watch for thoughts such as:
 - “Nothing will ever help”
 - “I can’t live like this.”
 - “Using is the only way to get relief.”
 - Reframe: “Pain is severe right now, but I’ve managed flares before and have a plan.”

Supporting Relapse Prevention when Pain Remains Unresolved

- Create a Pain-Flare Action Plan
 - Write plan for worsening pain that does not involve non-prescribe opioids.
 - Relaxation Techniques (e.g. Mindfulness)
 - Heat/Ice
 - Stretching or activity modification
 - Support person to call – “Who are you going to call?” – prepare that person ahead of time.
 - Behavioral health contact
 - Recovery meetings
 - When to contact the healthcare team
 - Non-opioid medications when appropriate
 - Goal shifts from eliminating pain to improving function and quality of life

Sample Relapse Prevention Message

- Say to patient: “Persistent pain can increase the risk of relapse, so our goal is not to wait until the pain is gone. Instead, we will build a plan that helps you manage pain flare-ups safely, maintain recovery, and improve your day-to-day functioning. The entire care team will work together to provide consistent support and recommendations.” (sample patient communication)



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