How Do State Policies Address Pain and Addiction?

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I. Background

As inadequate pain relief is increasingly recognized as a major public health problem, abuse and diversion of prescription pain medications also has critical public health implications. State policies adopted to minimize prescription drug abuse and diversion can unintentionally contribute to inadequate pain relief by creating barriers for practitioners. For example, addiction-related policy definitions may not conform to currently-accepted medical and scientific knowledge; such definitions can equate addiction with physical dependence, and can lead healthcare practitioners to view patients who have been treated with opioids for a prolonged period, and as a consequence are likely to be physically dependent, as addicts. The ideal policy environment for pain management is a balanced one, in which policies aimed at minimizing abuse and diversion of medications do not interfere with medical practice and patient care.[1]

Studies show that healthcare practitioners can be unwilling to treat pain in patients with an addictive disease.[2-3] Such patients also are especially likely to be adversely affected by policy restrictions, as effective pain management requires practitioners to make treatment decisions based on individual patient needs.[4]

The Pain & Policy Studies Group (PPSG) has developed a conceptual framework and research methodology, based on the principle of Balance, to evaluate and identify state policies that can affect professional practice and patient access to pain medications.[5] Three policy evaluations were conducted (in 2000, 2003, and 2005) to identify relevant policy language.

II. Objective

This analysis examines the extent and nature of the current policies that are particularly relevant for patients experiencing pain who also have an addictive disease or a history of addictive disease. States can have policy language that relates to five categories:

(1) defines or conceptualizes addiction and related terms (i.e., drug-dependent person, chemical dependency, and habituation) that are *consistent* with current medical and scientific understanding,

(2) defines addiction and related terms that are *inconsistent* with current medical and scientific understanding,

(3) reflects both consistent and inconsistent addiction-related definitions,

(4) restricts the treatment of individuals with addictive disease, and

(5) restricts the treatment of individuals with addictive disease and have addiction-related definitions.

Figure 1 presents examples of policy language from Categories 1, 2, and 4.

III. Methodology

In 2000, the PPSG conducted a systematic content evaluation of state controlled substances and medical and pharmacy practice statutes and regulations, as well as other healthcare regulatory policies such as guidelines and policy statements. These policies were analyzed by four policy researchers, who applied a set of 17 criteria designed to identify policy language having the potential to either enhance or impede the use of controlled substances for pain management.[5]

In 2003, the policy evaluation was updated.[6]

In 2005, previous policy language was verified as still being present, and a Boolean search of statutes and regulations using key terminology identified new policy language regarding addiction-related language.

IV. Presentation of Results (see Tables 1 and 2 and Figure 2):

Table 1. Number of States with Relevant Policy Language

	No. (%)
(1) Addiction-related terminology or concepts that are *consistent* with current medical and scientific understanding	29 (58%)
(2) Addiction-related terminology that is *inconsistent* with current medical and scientific understanding	18 (36%)
(3) Conflicting addiction-related terminology or concepts (i.e., states that have a definition that is *consistent* with current medical and scientific understanding, in addition to having a definition that is *inconsistent*)	9 (18%)
(4) Restrictions on the treatment of individuals with addictive disease	7 (14%)
(5) Both restrictions and addiction-related definitions	6 (12%)

IV. Results

Table 2. Relevant Language Found in Three Types of Policies

	No. of examples identified		
	Statutes	Regulations	Healthcare Board
Addiction-related terminology or concepts that are *consistent* with current medical and scientific understanding	0	7	27
Addiction-related terminology that is *inconsistent* with current medical and scientific understanding	15	3	2
Restrictions on the treatment of individuals with addictive disease	6	1	0

Figure 2

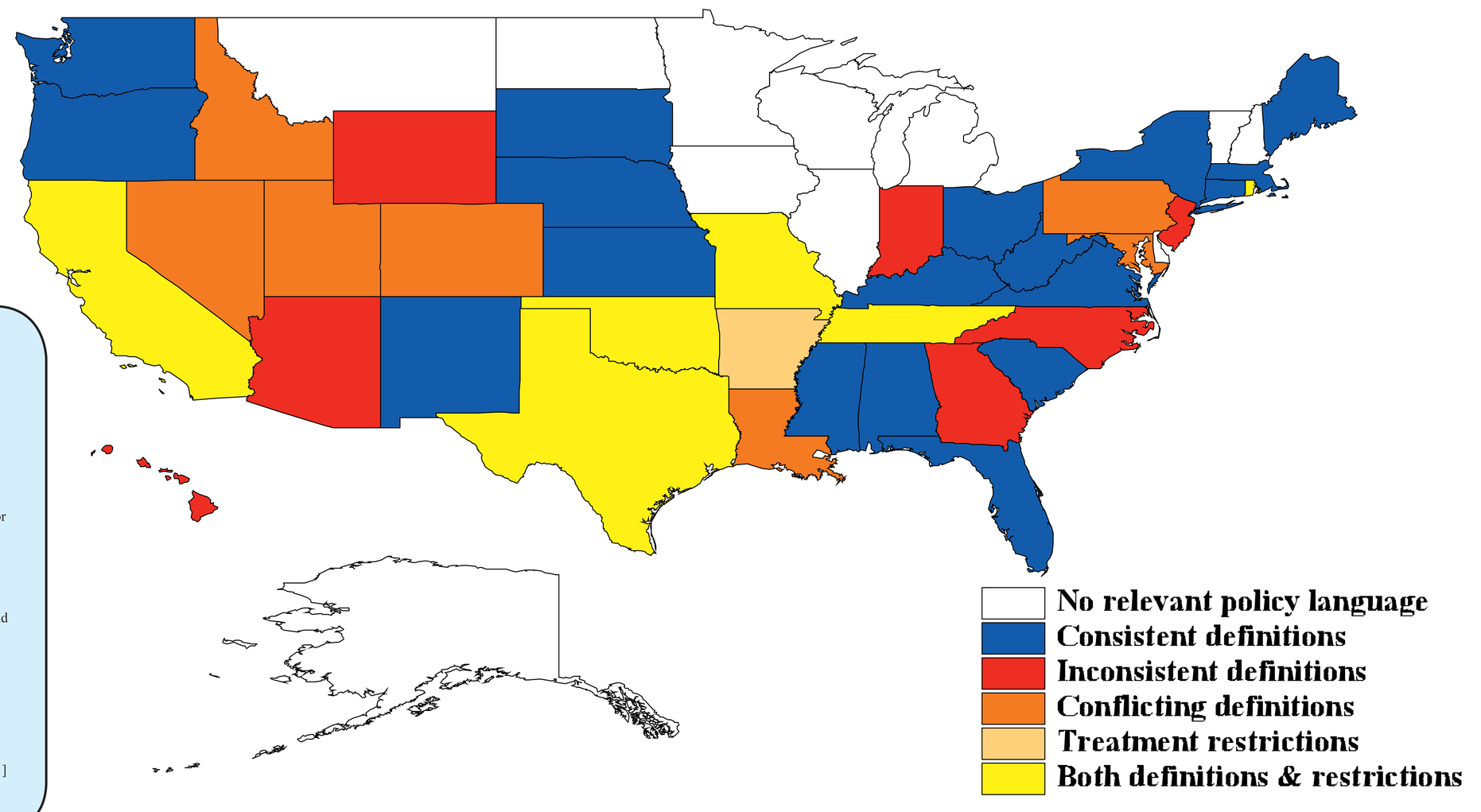

Figure 1: Examples of Relevant Policy Language

CATEGORY 1: Definitions or conceptualizations of addiction-related terminology that are consistent with current medical and scientific understanding.

- Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction. [Kansas State Board of Healing Arts, Guidelines for the Use of Controlled Substances for the Treatment of Pain. Approved: October 17, 1998]

CATEGORY 2: Definitions of addiction-related terminology that are inconsistent with current medical and scientific understanding.

- The term Drug Dependent Person means a person who is using a controlled substance and who is in a state of psychic or physical dependence, or both, arising from the use of that substance on a continuous basis. [Arizona Controlled Substances Act 36-2501]

CATEGORY 4: Restrictions on the treatment of individuals with addictive disease.

- This section shall not authorize a physician and surgeon to prescribe or adminster controlled subtances to a person the physician and surgeon knows to be using drugs or substances for nontherapeutic purposes. [California Business and Professions Code 2241]

V. Conclusions

- The majority of consistent addiction-related terminology or concepts was found in healthcare regulatory board policies. Addiction-related terminology found in law typically stems from a 1964 WHO definition and does not reflect the current medical and scientific understanding of addictive disease.[7]

  Such definitions could apply to a pain patient who is physically dependent as a result of opioid treatment. This can stigmatize all patients with pain, and erroneously suggests that the chronic medical use of opioids for pain results in drug dependence.

- Many of the restrictive policies were adopted in the early 1970's, when pain management was not considered to be an accepted part of standard medical practice.

  A majority of the restrictive policy language can be found in statutes, rather than in healthcare regulatory board policies.

  States that prohibit prescribing to addicts are more restrictive than federal policy, which does not limit prescribing to treat pain in individuals with an addictive disease.[8]

- Many state initiatives have recently aimed at improving pain management for all patients, including those with current or past addictive disease, by adopting consistent addiction-related definitions and repealing policy restrictions.[9]

  States have tended to use the 1998 Federation of State Medical Boards *Model Guidelines* for state healthcare regulatory boards, which contained positive language related to treating pain in addictive disease, as well as, definitions of key addiction-related terminology which were consistent with current medical and scientific understanding.[10] This policy was recently revised in 2004, preserving the very important language related to treating pain and addictive disease [11] and taking advantage of consensus definitions for addiction-related terms created by three national professional organizations interested in the interface between addiction and pain management.[12]

VI. Recommendations

- Policymakers and healthcare regulators should work together to remove excessive restrictions on prescribing pain medications to individuals with addictive disease.

- Policies with inappropriate addiction-related terminology or concepts should be revised to attain consistency with the most current medical and scientific understanding of addictive disease.

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