

**Screening for Addiction and
Monitoring for Aberrant Behavior in
Patients with Chronic Pain**

Objectives

- Define and distinguish the concepts of addiction, substance abuse, dependence and pseudoaddiction.
- Identify epidemiological and clinical risk factors for aberrant behavior in populations with chronic pain.
- Demonstrate the ability to use clinical tools to assess risk of addiction.
- Develop practical strategies to manage aberrant behavior.

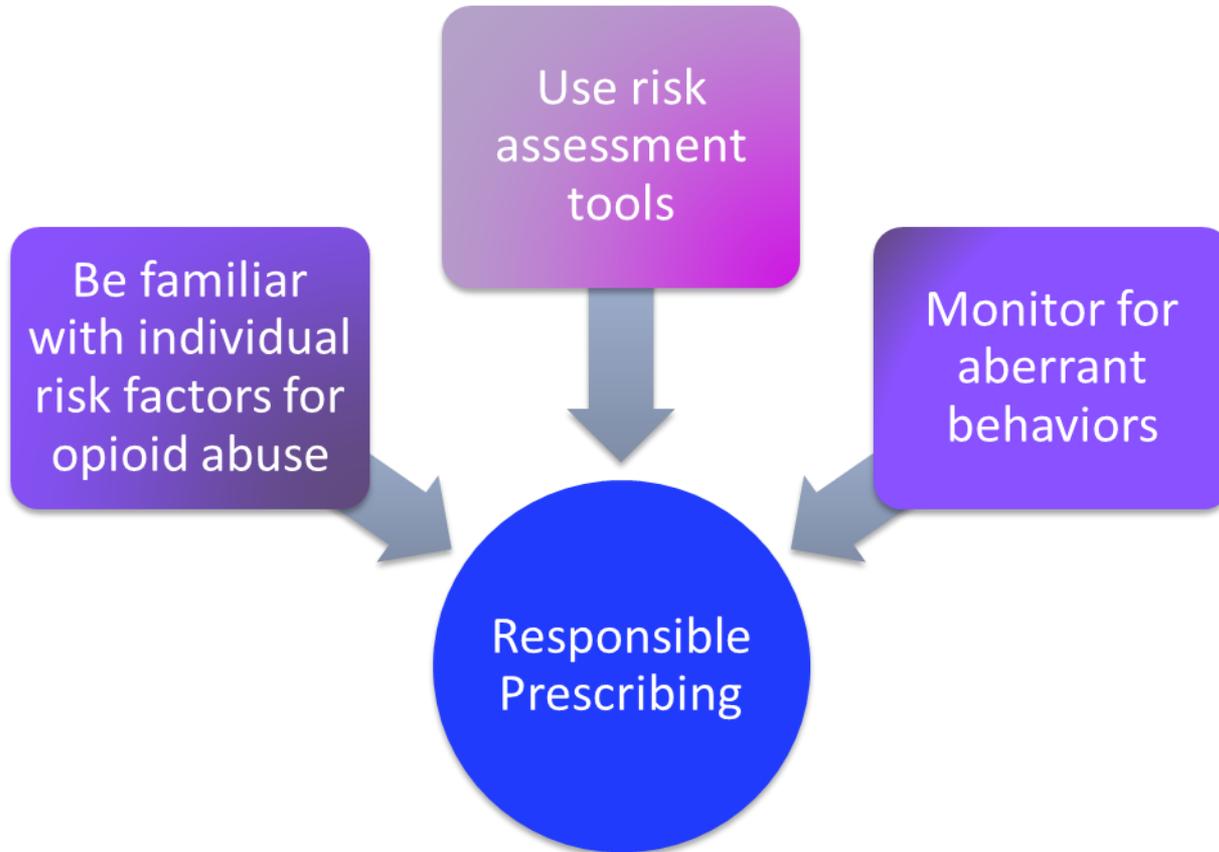
Daniel P. Alford, MD, MPH, FACP, FASAM, opioid expert and associate professor of medicine at BU:

“WARNING...

A controversial statement follows...

I strongly believe that physicians can be trained to prescribe opioids for chronic pain **safely** and **effectively.**”

Framework for opioid risk management



ASAM Definition of Addiction

- A primary, chronic disease of brain reward, motivation, memory and related circuitry.
- Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations.
- This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

<http://www.asam.org/DefinitionofAddiction-LongVersion.html>

Aberrant Behavior

Aberrant Behavior is behavior that suggests prescription misuse, abuse, or addiction. (SAMSHA TIP 54)

“Prescribing opioids will lead to abuse/addiction in a small percentage of chronic pain patients, but a larger percentage will demonstrate ADRBs and illicit drug use. These percentages appear to be much less if CPPs are preselected for the absence of a current or past history of alcohol/illicit drug use or abuse/addiction.” (Fishbain et al.)

Prevalence of Addiction in Chronic Pain Patients

- Structured review of available studies of development of aberrant behavior/addiction in patients on opioids for chronic pain.
- 24 studies with 2,057 patients with rate of 3.27% for abuse/addiction.
- Rate of abuse/addiction in patients with no past or current SUD was 0.19%
 - Fishbain DA. *Pain Med.* 2008;9:444-58.

Aberrant Behavior Prevalence

- 17 studies of 2,466 chronic pain patients found rate of 11.5% for aberrant behavior.
- For patients without SUD, rate was 0.59%.
- 5 studies (15,542 patients) by urine toxicology: 20.4% had no Rx opioid or an opioid not prescribed.
- 5 studies (1,965 patients): 14.5% had illicit drugs.

Risk Factors for aberrant behavior

- Lifetime history of substance use disorder (alcohol, tobacco, illicit substances)
- Psychiatric co-morbidity
- History of pre-adolescent sexual abuse
- Family history of substance abuse
- History of legal problems
- Younger age (16 – 45)
- Increased functional impairment

Risk Factors Predictive of Dependence

- Analysis of electronic health records of outpatients receiving 4 or more prescriptions for opioids in last 12 month for chronic pain.
- Diagnostic interviews with 705 patients.
 - Boscarino JA. *Addiction*. 2010;105:1776-1782.
- Age > 65, pain impairment, MDD and use of psychotropic medications had a combined OR of 8.
- Adding history of opioid abuse or severe dependence raised OR to 56.

Spectrum of Aberrant Behaviors: *mild*

- Requests for higher doses
- Requests for specific formulation
- Occasional loss of prescription
- Occasional increase of dose
without permission

Spectrum of Aberrant Behaviors: *moderate*

- Use of Rx to treat symptom other than pain
- Stockpiling Rx in time of reduced symptom
- Significant energy spent assuring supply
- Multiple unsanctioned dose escalations
- Recurrent prescription losses
- Decline in function from baseline
- Concurrent use of illicit substances

Spectrum of Aberrant Behaviors: *severe*

- Continual escalation of dose
- Seeking Rx from other providers or ER
- Stealing drugs
- Consistently buying Rx off street
- Diverting/Selling Rx
- Forging prescriptions
- Injection of oral Rx

Risk Assessment Tools

- **SOAPP[®]-R**
 - 24 item patient reported mood sx, family history, legal history, designed to predict which pts require more monitoring, has associated monitoring/treatment recommendations.
 - Sensitivity 81%, specificity 68%, PPV 57%, NPV 87%
 - Cutoff score of 18
- **DAST[©]**
 - 28 item patient report on prescription use, substance use behaviors.
- **DIRE[©]**
 - Clinician rated assessment of 4 domains: dx, intractability, risk, efficacy.
- **ORT[©]**
 - Patient reported personal and family hx substance abuse, age, psychiatric dx, age, hx sexual abuse. Stratifies into low, moderate, high risk.

Ongoing Risk Assessment Tool

- **COMMTM**
 - 17 item patient self-reported medication use behaviors over previous 30 days
 - Score of 9 or above has positive LR 3.48 and negative LR 0.08 for medication misuse

All cited risk tools are available online:

<http://www.painedu.org>

<http://www.emergingsolutionsinpain.com>

How to use risk assessment tools

- Should not be used to deprive patients of pain management or opioid therapy but to identify those who are at risk for addiction.
- Use only with informed consent with advisement that refusal may for safety reasons alter treatment plan.
- They should be used to help guide us to determine the frequency and intensity of monitoring during the course of treatment.
- They should be use to develop the most efficacious and safest treatment strategy.

Balancing Benefits/Risks

- There are no absolute rules: ongoing analysis of risk/benefit balance in each individual case.
- Involve patient in process of shared decision- making and mutual rights and responsibilities.
- Document your reasoning for continued use based on function and lack of side effects.
- Obtain early and frequent consultation for challenging cases and problem behaviors.

Judge the Treatment NOT the Patient



Appropriate

Do the benefits of this treatment outweigh any side effects and risks of harm to the patient or society?

Not Appropriate

Is the patient good or bad?

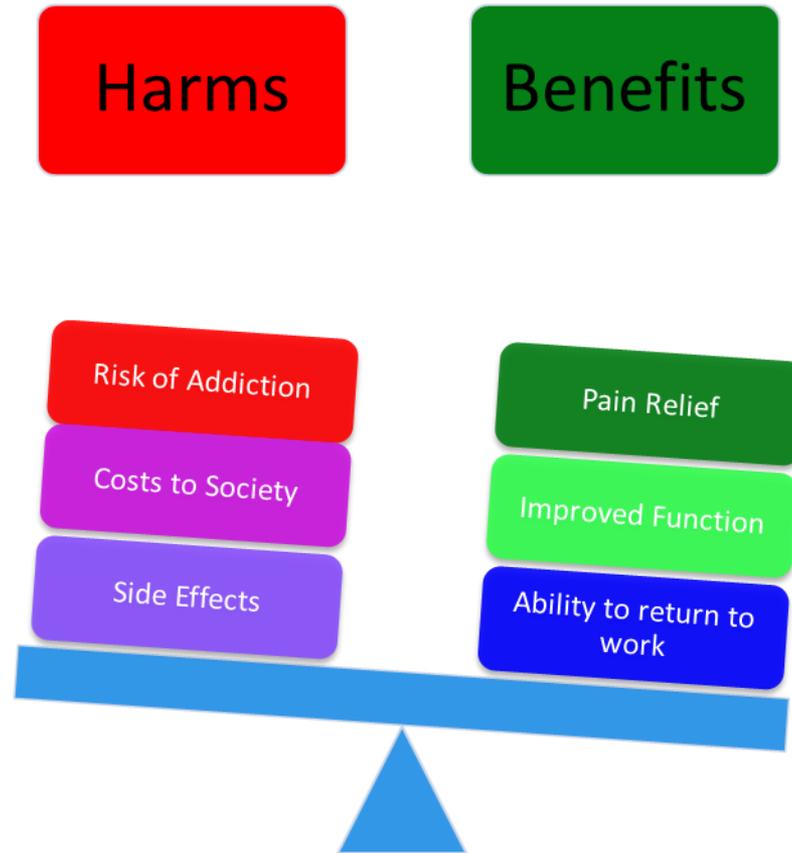
Does the patient deserve pain meds?

Should I trust the patient?

Should he/she be punished or rewarded?

Adapted from Alford

Balancing Benefits/Harms



Balancing Benefits/Risks

- Clinical interview and judgment are still the gold standard of risk assessment/management.
- Patients with addiction less likely to use illicit drugs if painful conditions controlled.
- Less risk of developing other addiction-related diseases (HIV, Hep C, syphilis) due to IV drug use.
- Less risk of developing addiction to other substances of abuse if pain controlled.

Management of Risk

- **UNIVERSAL PRECAUTIONS: *every patient is potentially at risk***
 - Opioid agreements
 - Risk screening and ongoing assessment
 - Monitoring of urine toxicology
 - Prescription monitoring programs
 - Pill counts for those at high risk
 - Frequent visits with limited number of pills dispensed for those at high risk

Management of Risk: Opioid Agreements

- Mainly a tool to communicate expectations of both provider and patient.
- A means of obtaining informed consent.
- Educate patient on rationale, risks/benefits.
- Set specific goals (functional).
- Set expectations for monitoring.
- Identify specific responses for aberrant behaviors.

Management of Risk: Urine

Toxicology

- Always obtain informed consent.
- Use results therapeutically.
- Know the limitations of toxicology screens.
- A tool for assessing adherence with medical treatment plan just like checking blood sugar in diabetes.
 - Main utility of standard toxicology is to identify use of illicit substances
- Adjust frequency of monitoring to match level of risk.

Managing Aberrant Behavior within the Practitioner-Patient Relationship

- Medicalize, don't stigmatize the non-adherence, as with any other disease such as diabetes.
- Ask and try to empathically understand the reasons for the behavior.
- Be open and non-judgmental regarding the explanation even if you don't believe it.

Questions For Patient and Practitioner

Patient

- Were you confused about how to take the prescription?
- Did you think more pills, more relief?
- Were you overly active and then have more pain & take more?
- Have you been depressed or anxious and the drugs made you feel better?

Practitioner

- Has the pain condition progressed?
- Is there a new pain generator?
- Is there an undiagnosed psychiatric disorder needing treatment?
- Have you set and followed limits and rules?
- (SAMSHA TIP 54)

Therapeutic Responses to Mild/Moderate Aberrant Behaviors

- Increase frequency of visits, even if brief check ins with nursing staff.
- With permission, obtain collateral information/family support for plan.
- Increase frequency or sophistication of toxicology screening, e.g., test for alcohol.
- Provide smaller quantities of opioids and other controlled substances.

When to Taper Opioids

- Moderate-severe aberrant behavior that continues despite repeated warnings and implementation of more close monitoring.
- Humane, long taper if can be safely done.
- Begin alternative pharmacological and non-pharmacological treatments for pain.
- DO NOT abandon the patient even if you refer.

When to **stop opioids**

- Patients exhibit aberrant behaviors in the severe category and represent a danger to the patient and the public.
- Danger such that may not allow humane tapering.
 - Injection of oral medication
 - Selling prescription
 - Forging/stealing prescription

When to refer to an addiction expert

- Aggressive demands for medications.
- Forging or stealing prescriptions.
- Selling or diverting medications
- Obtaining drugs from multiple prescribers
- Injecting oral/topical medications

Adapted from NY State Office of Alcoholism and Substance Abuse Services: Clinical Practice Guidance Number 2012.2: Referral to a Pain or Addiction Specialist. Available at <http://www.oasas.ny.gov/AdMed/recommend/guide2ref.cfm>

When to refer to pain expert

- Uncertain or questions about whether to use opioids to treat chronic pain.
- Patient with multiple psychiatric and medical comorbidities who needs opioids chronically.
- Complexity and risk profile of patient requires a level of documentation and monitoring not available in the practice setting.
- Intensity of pain & disability requires other pain interventions.

Summary

- The management of chronic pain with opioids is challenging and rewarding.
- Practitioner's responsibility is to provide:
 - Evidence-based risk assessment
 - Individualized treatment plan
 - Ongoing monitoring of functioning, adherence, impairment, and psychiatric symptoms.
 - Responsible prescribing.

References and More

- Gavin DR; Ross HE; Skinner HA. (1989) 'Diagnostic validity of the Drug Abuse Screening Test in the assessment of [DSM-III drug disorders](#)', *British Journal of Addiction* 84(3): 301-307.
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- Yudko E, Lozhkina O, Fouts A. A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *J Subst Abuse Treat.* 2007;32:189-198
- Belgrade MJ, Schamber CD, Lindgren BR. The DIRE Score: Predicting Outcomes of Opioid Prescribing for Chronic Pain. *J Pain.* 2006;7:671-681.