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

- Use risk assessment tools
- Be familiar with individual risk factors for opioid abuse
- Monitor for aberrant behaviors

Responsible Prescribing
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.

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%
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.
- 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 ensuring 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

• **COMM™**
  – 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

<table>
<thead>
<tr>
<th><strong>Appropriate</strong></th>
<th><strong>Not Appropriate</strong></th>
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<tbody>
<tr>
<td>Do the benefits of this treatment outweigh any side effects and risks of harm to the patient or society?</td>
<td>Is the patient good or bad?</td>
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<tr>
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<td>Does the patient deserve pain meds?</td>
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<td>Should I trust the patient?</td>
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<td></td>
<td>Should he/she be punished or rewarded?</td>
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Adapted from Alford
Balancing Benefits/Harms

**Harms**
- Risk of Addiction
- Costs to Society
- Side Effects

**Benefits**
- Pain Relief
- Improved Function
- Ability to return to work
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


