Identifying and Intervening Problematic Medication Use Behaviors

Stephen A. Wyatt, D.O.
Addiction Psychiatrist
Middlesex Hospital
Middletown, CT

Disclosures

- None

Outline

Introduction The Opiate Problem	• How did it occur? • Identifying the problem with opiates

Ways in which problems occur	• Appropriate treatment for the presenting problem.
	  • Nociceptive and Neuropathic Pain
	  • Chronic Non-Cancer Pain
	• Appropriate evaluation prior to the initiation of opioid treatment

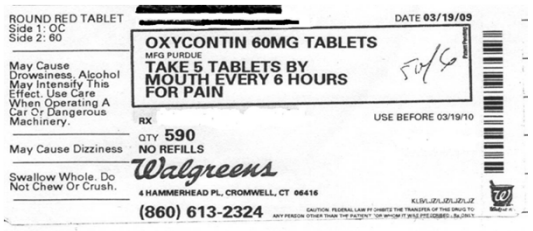
Problems associated with the prolonged use of opioid medication	• Observing for abberant behavior • Ongoing monitoring • Discussing these difficult problems with patients
The Goal	• Reduce Dependency • Reduce Suffering • Improve function

Case Presentation - PL

- 57 M,C,♂
- Hospitalized 11-08 d/t to Klonopin od
- Alcohol related injure at 25y/o resulting in a hip replacement.
- Injury to his back at 32 resulting in disability. Onset of prescribed opiates
- Remained on disability
- Vicodin (acetaminophen 500mg, Hydrocodone 5mg) #7 / 6 times a day. (#588/14d)
- Suggested long acting opioid

Case Presentation - PL

- Came for consultation 3/09 Oxycontin 60mg #5 4 time a day



The Value of Pain

Pain is our body's system alerting us to a problem.

Put your hand on a hot plate and you move it away quickly!

Hurt your ankle and you limp attempting to reduce the pain and allow the injury to heal.

Without pain, we could sustain more injury.

Adaptation to pain

•Once the pain system identifies the problem is no longer indicating a worsening problem the pain feedback mechanism modulate is isolated and reduced.

•This can also happen occur through perception of pain by cognition and conditioning.

•Medications can augment these adaptations or disrupt them.

The challenge is that
"treating pain is neither an absolute science nor risk-free"

Scott M. Fishman, MD - Anesthesia & Analgesia. 2007;105:8-9

History

- In 1872, California passed the first anti-opium law.
  - The administration of laudunum, an opium preparation, or any other narcotic constituted a felony.
    - Private use was not covered by the legislation.
  - Same year, California became the first state to establish a separate bureau to enforce narcotic laws, and one of the first states to treat addicts.
- Connecticut, in 1874, established the narcotic addict was incompetent to attend to his personal affairs.
  - The law required that he be committed to a state insane asylum for "medical care and treatment."
- Nevada, in1877, first to make it illegal to sell or dispense opium without a physician's prescription.
- Oregon, in 1887, first to pass a comprehensive anti-substance abuse law.

History

The federal Harrison Narcotic Act was passed in 1914.
Official title of the Harrison bill had been "An Act to provide for the registration of, with collectors of internal revenuer and to impose a special tax upon all persons who produce, import, manufacture, compound, deal in, dispense, sell, distribute, or give away opium or coca Leaves,* their salts, derivatives or preparations, and for other purposes."

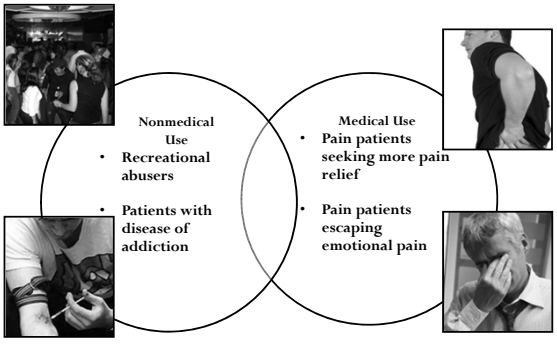
After passage of the law, this clause ["in the course of his professional practice only"] was interpreted by law-enforcement officers to mean that a doctor could not prescribe opiates to an addict to maintain his addiction.

Prevalence of Recurrent and Persistent Pain in the US

- 1 in 4 Americans suffer from recurrent pain (day-long bout of pain/month)
- 1 in 10 Americans report having persistent pain of at least one year's duration
- 1 in 5 individuals over the age of 65 report pain persisting for more than 24 hours in the preceding month
  - 6 in 10 report pain persisting > 1 year
- 2 out of 3 US armed forces veterans report having persistent pain attributable to military service
  - **1 in 10 take prescription medicine to manage pain**

American Pain Foundation. http://www.painfoundation.org. Accessed March 2010.

Who Misuses/Abuses Opioids and Why?



The Problem of Pain

- Costs US economy estimated $100 billion/year
  - Healthcare
  - Welfare & disability payments
  - Lost tax revenue
  - Lost productivity (work absence)
- 40 million physician visits annually
  - Most common reason for medical appointments
- Push toward opioid maintenance therapy in non malignant pain

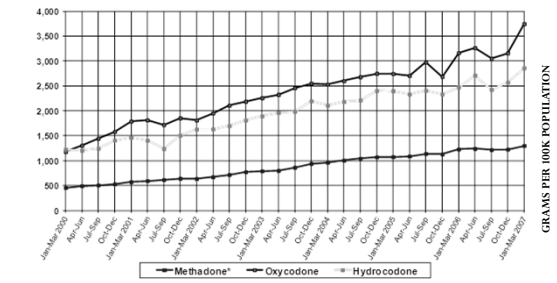
National Institutes of Health. *New Directions in Pain Research*. Sept 1998. PA-98-102.

Pain Standards

- JCAHO – Installs a Quality Standard on pain identification. (2001)
- Strong encouragement to increase the identification and treatment of pain.
- The development of new and very effective opiates for the treatment of pain.
- The tremendous rise in the prescription of opiates for non-cancer pain.

Trend data: Distribution of prescription opioids, U.S., 2000–2007

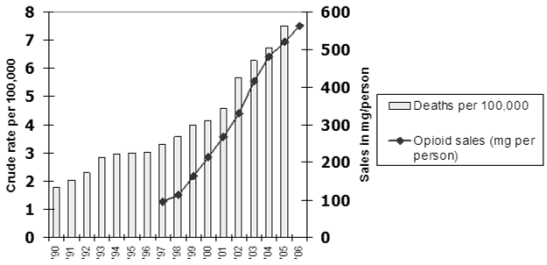
Source: DEA, ARCOS system, 2007



* Includes OTPs

Deaths per 100,000 related to unintentional overdose and annual sales of prescription opioids by year, 1990 - 2006

Source: Paulozzi, CDC, Congressional testimony, 2007



"Doctors are easy to find and they don't carry guns" Medical Economics

- "To stop Rx diversion, the agency (DEA) has hired hundreds of new investigators and expanded it's local and state task forces"
- "Quantity alone…may indicated diversion and trigger an investigation"

FSMB Model Policy

Basic Tenets

- Pain management is important and integral to the practice of medicine
- Use of opioids may be necessary for pain relief
- Use of opioids for other than a legitimate medical purpose poses a threat to the individual and society
- Physicians have a responsibility to minimize the potential for abuse and diversion
- Physicians may deviate from the recommended treatment steps based on good cause
- Not meant to constrain or dictate medical decision-making

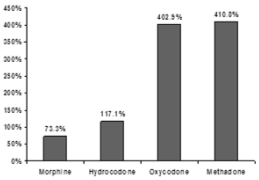
FSMB, Federation of State Medical Boards

NASPER

National All Schedules Prescription Electronic Reporting Act

- Signed into law by President Bush August 2005
- Point of care reference to all controlled substances prescribed to a given patient
- Each state will implement it's own program
- Treatment tool vs. Law enforcement tool?

Sale of Opioids 1997-2002



Source: 2002 National Survey on Drug Use and Health (NSDUH). Results from the 2002 National Survey on Drug Use and Health: National Findings. Department of Health and Human Services

Opioid Abuse-Deterrent Strategies Hierarchy

Increasing Direct Abuse Deterrence

Combination Mechanisms
Pharmacologic • Sequestered antagonist • Bio-available antagonist • Pro-drug
Aversive Component • Capsaicin – burning sensation • Ipecac – emetic • Denatonium – bitter taste
Physical • Difficult to crush • Difficult to extract
Deterrent Packaging • RFID – Protection • Tamper-proof bottles
Prescription Monitoring

Opioid Renewal Clinic

What is the impact of a structured opioid renewal program?

- Primary goal: reduce oxycodone SA use to 3% of opioids
- Setting
  - Primary care
  - Managed by nurse practitioner and clinical pharmacist
  - Philadelphia VA pain clinic
- Structured program
  - Electronic referral by PCP
    - Signed Opioid Treatment Agreement
    - UDT
  - Support from multidisciplinary pain team: addiction psychiatrist, rheumatologist, orthopedist, neurologist, and physiatrist
  - Multimodal management
    - Opioids
    - NSAIDs and acetaminophen for osteoarthritis
    - Transcutaneous electrical stimulation (TENS) units
    - Antidepressants and anticonvulsants for neuropathic pain
    - Reconditioning exercises

Wiedemer NL, et al. *Pain Med*. 2007;8(7):573-584.

Considerations

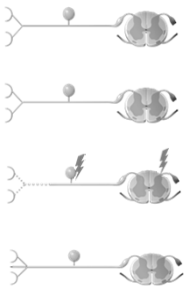
- What is conventional practice for this type of pain or pain patient?
- Is there an alternative therapy that is likely to have an equivalent or better therapeutic index for pain control, functional restoration, and improvement in quality of life?
- Does the patient have medical problems that may increase the risk of opioid-related adverse effects?
- Is the patient likely to manage the opioid therapy responsibly?
- Who can I treat without help?
- Who would I be able to treat with the assistance of a specialist?
- Who should I not treat, but rather refer, if opioid therapy is a consideration?

Fine PG, Portenoy RK. *Clinical Guide to Opioid Analgesia*. Vendome Group, New York, 2007.

Pain

- Acute Pain
  - Trauma, injury, dental procedures, and labor and delivery
- Chronic Malignant Pain
  - Cancer
- Chronic Nonmalignant Pain
  - Arthritis, Disc Disease
- Withdrawal-related Pain

Multiple Types of Pain



Examples
• Strains and sprains • Bone fractures • Postoperative
• Osteoarthritis • Rheumatoid arthritis • Tendonitis
• Diabetic peripheral neuropathy • Post-herpetic neuralgia • HIV-related polyneuropathy
• Fibromyalgia • Irritable bowel syndrome

- Patients may experience multiple pain states simultaneously[1]

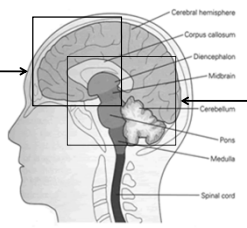
Adapted from Woolf CJ. *Ann Intern Med.* 2004;140:441-451.
1. Chong MS, Bajwa ZH. *J Pain Symptom Manage.* 2003;25:S4-S11.

Pain

- Perception of pain as a 4-step model
  - **Transduction**: Acute stimulation in the form of noxious thermal, mechanical, or chemical stimuli is detected by nociceptive neurons.
  - **Transmission**: Nerve impulses transferred via axons of afferent neurons from the periphery to the spinal cord, to the medial and ventrobasal thalamus, to the cerebral cortex
  - **Perception**: Cortical and limbic structures in the brain are involved in the awareness and interpretation of pain.
  - **Modulation**: Pain can be inhibited or facilitated by mechanisms affecting ascending as well as descending pathways.

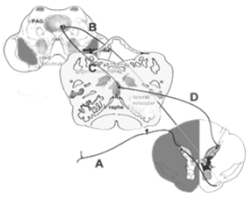
The Pain Pathway

Perception
- Cerebral Cortex



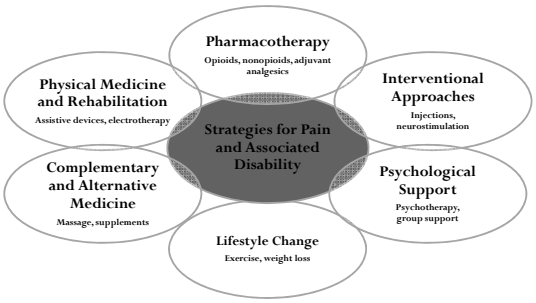
Modulation
- Midbrain
- Thalamus,
- Limbic system

Modulation of Pain



•*Descending Pain Regulation:*
- **norepinephrine -** alpha-2 stimulatory effects
- **serotonin**
- o**piates** relieve pain by stimulating mu and delta receptors at a host of sites.

Multimodal Treatment



There is more to treating pain than Opiates….

but opiates remain important!

Risk Assessment Tools

- Addiction Severity Index (ASI)
  - Assess current and lifetime substance-use problems and prior treatment
- Drug Abuse Screening Test (DAST-10)
  - Screen for probably drug abuse or dependence
- Addiction Behaviors Checklist (ABC)
  - Evaluate and monitor behaviors indicative of addiction related to prescription opioids in patients with chronic pain

Passik SD, Squire P. *Pain Med.* 2009;10 Suppl 2:S101-14.

Risk Assessment Tools (cont)

- Screening Instrument for Substance Abuse Potential (SISAP)
  - Identify individuals with possible substance-abuse history
- Opioid Risk Tool (ORT)
  - Predict which patients might develop aberrant behavior when prescribed opioids for chronic pain
- Diagnosis, Intractability, Risk, Efficacy (DIRE)
  - Predict the analgesic efficacy of, and patient compliance to, long-term opioid treatment in the primary care setting

Passik SD, Squire P. *Pain Med.* 2009;10 Suppl 2:S101-14.

Opioid Risk Tool

- 5-item initial risk assessment
- Stratifies risk into low (6%), moderate (28%) and high (91%)
  - Family History
  - Personal History
  - Age
  - Preadolescent sexual abuse
  - Past or current psychological disease
- www.emergingsolutionsinpain.com

Webster, Webster. Pain Med. 2005

D.I.R.E. Score: Patient Selection for Chronic Opioid Analgesia
For each factor, rate the patient's score from 1-3 based on the explanations in the right hand column

Score	Factor	Explanation
	Diagnosis	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, non-specific back pain. 2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
	Intractability	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
	Risk	(R= Total of P+C+R+S below)
	Psychological:	1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	Chemical Health:	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2 = Chemical coper (uses medications to cope with stress) or history of CD in remission. 3 = No CD history. Not drug-focused or chemically reliant.
	Reliability:	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through. 2 = Occasional difficulties with compliance, but generally reliable. 3 = Highly reliable patient with meds, appointments & treatment.
	Social Support:	1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school and no social isolation.
	Efficacy score	1 = Poor function or minimal pain relief despite moderate to high doses. 2 = Moderate benefit with function improved in a number of ways (or insufficient info- hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and function and quality of life with stable doses over time.

_____Total score = D + I + R + E

Score 7-13: Not a suitable candidate for long-term opioid analgesia
Score 14-21: Good candidate for long-term opioid analgesia
Reproduced with permission from Mies Belgrade[4]

Source: Journal of Pain, The, 2009, 10.113.130.22 (DOI:10.1016/j.jpain.2008.10.008)

Risk Assessment Tools (cont)

- Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R)
  - Predict aberrant medication-related behaviors in patients with chronic pain considered for long-term opioid therapy
    - Empirically-derived, 24-item self-report questionnaire
    - Reliable and valid
    - Less susceptible to overt deception than past version
    - Scoring: ≥ 18 identifies 90% of high-risk patients

Passik SD, Squire P. *Pain Med*. 2009;10 Suppl 2:S101-14.
Butler SF, et al. *J Pain*. 2008;9:360-372.

SOAPP

Name:_____ Date:_____

The following survey is given to all patients who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?
   0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?
   0 1 2 3 4
3. How often have you taken medication other than the way that it was prescribed?
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?
5. How often in your lifetime have you had legal problems or been arrested?

Please include any additional information you wish about the above answers. Thank you
0 1 2 3 4

To score the SOAPP, add ratings of all questions.

A score of 4 or higher is considered positive

Risk Assessment Tools (cont)

- Pain Medication Questionnaire (PMQ)
  - Assess risk for opioid medication misuse in patients with chronic pain
- Current Opioid Misuse Measure (COMM)
  - Periodically monitor aberrant medication-related behaviors in patients with chronic pain currently on opioid therapy

Urine Drug Testing

- When to test?
  - Randomly, annually, PRN
- What type of testing?
  - POC, GS/MS
- How to interpret
  - Metabolism of opioids
  - False positive and negative results
- What to do about the results
  - Consult, refer, change therapy, discharge

Initiation of opioid therapy

- Is there a ***clear diagnosis***?
- Is there ***documentation*** of an adequate work-up?
- Is there ***impairment of function***?
- Has non-opioid multimodal therapy ***failed***?
- Have ***contraindications*** been ruled out?

Begin opioid therapy:

Document

Monitor

Avoid poly-pharmacy

Principles of Responsible Opioid Prescribing

- Drug selection, route of administration, dosing/dose titration
- Managing adverse effects of opioid therapy
- Assessing outcomes
- Written agreements in place outlining patient expectations/responsibilities
- Consultation as needed
- Periodic review of treatment efficacy, side effects, aberrant drug-taking behaviors

Medical issues in opioid prescribing

- Potential benefits
  - Analgesia
  - Function
  - Quality of life
- Potential risks
  - Toxicity
  - Functional impairment
  - Physical dependence
  - Addiction
  - Hyperalgesia

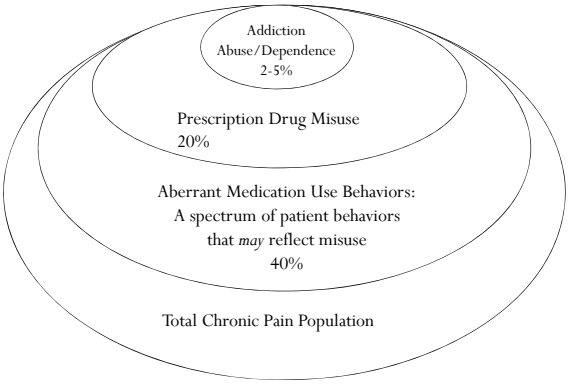
Conclusions as to opioid efficacy

- Opioids are an essential treatment for some patients with CNMP.
  - They are rarely sufficient
  - They almost never provide total lasting relief
  - They ultimately fail for many
  - They pose some hazards to patients and society
- It is not possible to accurately predict who will be helped – but those with contraindications are at high risk

Back Pain

- There has been 423% increase in the expenditure for spine-related narcotic analgesics from 1997 to 2004*
- Yet in assessment of health status there has been no significant improvement.

* JAMA February 13,2008 Vol. 299, No. 6



Adapted from Passik. APS Resident Course, 2007

Pain Treatment in Patients with an Addiction

- Address addiction
- Use non-pharmacologic approaches, if effective
- Use non-opioid analgesics, if effective
- Provide effective opioid doses, if needed
- Treat associated symptoms, if indicated
- Address addiction

Pain Treatment in Patients with an Addiction

- Avoid the patient's drug of choice
- Consider safer longer acting opioids
- Use medication with lower street value
- Avoid self administration, if possible
- Case management

Identifying and Managing Abuse and Diversion

- Assessing risk and aberrant behaviors
- Performing scheduled and random UDTs
- Utilization of PMPs
- Developing good communication with pharmacists
- Assessing stress and adequacy of pain control
- Receiving input from family, friends, and other patients

Aberrant Drug Related Behaviors - Less Predictive of an Addiction

- Aggressively complaining of the need for more drug
- Drug hoarding during periods of reduced pain
- Requesting specific drugs
- Openly acquiring similar drugs from other medical sources if primary provider is absent or under-treated
- Unsanctioned dose escalation or other non-compliance on one or two occasions

Signs of Potential Abuse and Diversion

- Request appointment toward end-of-office hours
- Arrive without appointment
- Telephone/arrive after office hours when staff are anxious to leave
- Reluctant to have thorough physical exam, diagnostic tests, or referrals
- Fail to keep appointments
- Unwilling to provide past medical records or names of HCPs
- Unusual stories

However, emergencies happen:
not every person in a hurry is an abuser/diverter

Drug Enforcement Administration. *Don't be Scammed by a Drug Abuser.* 1999.
Cole BE. *Fam Pract Manage.* 2001;8:37-41.

Aberrant Drug Related Behaviors - Predictive of an Addiction

- Selling prescription drugs
- Prescription forgery
- Stealing or "borrowing" drugs
- Obtaining prescription drugs form non-medical sources
- Concurrent abuse of alcohol or illicit drugs
- Multiple dose escalations or other non-compliance with therapy

Aberrant Drug Related Behaviors - Predictive of an Addiction

- Multiple episodes of prescription "loss"
- Prescriptions from other clinicians/EDs without seeking primary prescriber
- Deterioration in function that appears to be related to drug use
- Resistance to change in therapy despite significant side effects from the drug

Differential Diagnosis of Aberrant Drug-Taking Attitudes and Behavior

- Addiction (out-of-control, compulsive drug use)
- Pseudoaddiction (inadequate analgesia)
- Other psychiatric diagnosis
  - Organic mental syndrome (confused, stereotyped drug-taking)
  - Personality disorder (impulsive, entitled, chemical-coping behavior)
  - Chemical coping (drug overly central)
  - Depression/anxiety/situational stressors (self-medication)
- Criminal intent (diversion)

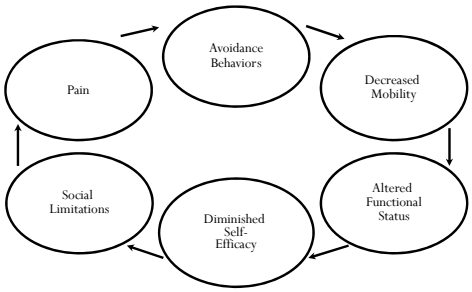
Passik SD, Kirsh KL. *Curr Pain Headache Rep.* 2004;8:289-294.

Pain and Affective Disorders

- It is common to see a concurrent depression or anxiety with persistent pain.
  - On occasion it is the dysphoria that lowers the pain threshold.
  - Chronic pain contribute to the development of an affective disorder.

JAMA. 1998;280:147-151

Vicious Cycle of Uncontrolled Pain



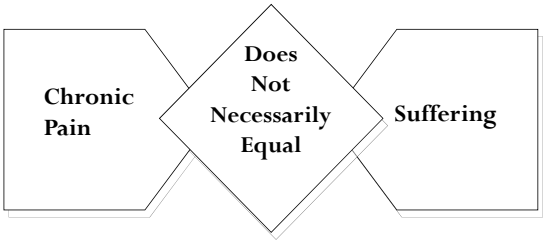
Perceived Pain - Suffering

- At risk patients
  - Past history of substance use disorder
  - Emotionally traumatized
  - Dysfunctional / alcoholic family
  - Lacks effective coping skills
  - Dependent traits
  - Stimulus augmenters-deficit in hedonic tone

Paul Farnum, MD PHP, BC

Case Presentation - LP

- Unable to taper at home
- Referred to Inpatient Detox for Induction to Buprenorphine
- Significant difficult in getting to moderate withdrawal state
- Inducted on 24mg of Buprenorphine
- Remains on this dose 2 years later.



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Some Resources

- www.AOAAM.org
- www.pcss-b.org
- www.painedu.com
  - PainEdu Manual
  - Opioid Risk Management Supplement
- www.pain.com
  - Links to many pain sites
- www.legalsideofpain.com
  - Current status of laws regarding opioid Rx
- www.partnersagainstpain
  - Purdue site with access to patient management forms