

# Should Opioid Abusers Be Discharged From Opioid-Analgesic Therapy?



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## Avoiding Harm

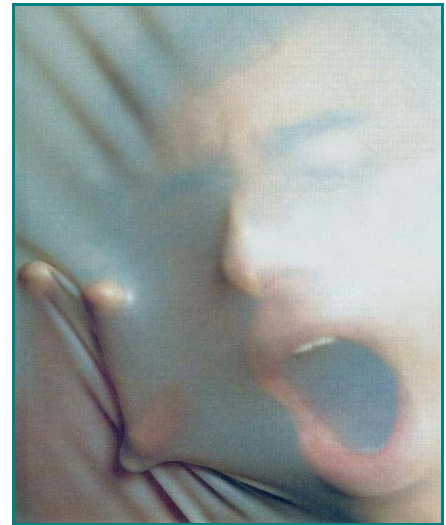
“Do no harm” – *primum non nocere* – is probably the best-known mandate implied by (but not literally stated in) the original Hippocratic Oath [Hutchison et al. 2006]. Although it is debated in certain modern contexts (ie, abortion, capital punishment, end-of-life issues), this tenet is reflected in medical practice to the degree that healthcare is increasingly guided by evidence-based guidelines that are both effective and safe (ie, do no harm). Unfortunately, an ongoing clinical practice with the potential to cause much harm to patients with chronic pain is that of discharging them from opioid therapy due to concerns about opioid-analgesic abuse or addiction.

Like diabetes or heart disease, addiction is a chronic progressive disease that, if present and left untreated, may result in significant morbidity and death. Reactive discharge from opioid-analgesic therapy due to concerns about opioid addiction or abuse can do significant harm, not just at the level of the individual, but also affecting families, the healthcare system, and society at large. Such practice should be avoided.

## Defining Addiction In Patients With Chronic Pain

Clearly not all discharges from opioid therapy are due to the presence of addictive disease (or *substance-use disorder* as defined by DSM-IV-TR [APA 2000]). Addiction concerns arise when the patient appears to be drug-seeking, noncompliant with opioid therapy, or using other illicit drugs. Yet, none of these behaviors provides evidence of addiction, and patients may be wrongly discharged secondary to medication-misuse behaviors that actually reflect pseudoaddiction (drug-seeking behaviors based on inadequate pain relief [Weissman and Haddox 1989]), a poorly treated Axis I or II psychiatric disorder, or general non-compliance with therapy.

After following a large sample of patients with chronic pain during one year of opioid therapy, recent data from our VA pain clinic showed that up to 28% were discharged for “medication misuse” behaviors [Compton et al. in press]. It is unknown how many of these opioid-misusing patients actually met psychiatric diagnostic criteria for a substance-use



*Discharging a patient with pain from opioid-analgesic therapy due to concerns about abuse and addiction can do significant harm on many levels.*

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disorder, but these discharges clearly captured a certain proportion of patients with untreated addictive disease.

Difficulties in determining the prevalence of opioid addiction in patients with pain are not simply due to a lack of sophistication on the part of practitioners but more often result from clinical challenges inherent in identifying addictive disease when the drug of abuse is medically prescribed [Passik et al. 2004; Portenoy 1996; Savage 2002]. Standardized diagnostic criteria (DSM-IV-TR) for opioid addiction [APA 2000] in pain-free populations have proven to be invalid or difficult to apply in the context of chronic pain and therapeutic opioid prescription [Chabal et al. 1997; Fishbain et al. 1992; Harden 2002; Miotto et al. 1996; Sees and Clark 1993].

Since they have sanctioned access to their opioid medications, patients with pain who become addicted to these drugs may be less likely to suffer the legal, employment, family, and social consequences typically associated with, and partially diagnostic of, a substance-use disorder. Furthermore, the two *objective* criteria for substance dependence according to the DSM-IV-TR – physical dependence and tolerance – are naturally expected, neurophysiologic sequelae of chronic opioid therapy and are not specific for addiction in this context.

Acknowledging the difficulties inherent in identifying opioid addiction in patients for whom opioids are therapeutically prescribed, the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine developed a consensus statement that provides clarifications regarding the presentation of addiction in chronic-pain populations [Consensus Document 2001]. In this document, addiction is defined as “a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations,” and it is characterized by behaviors that include one or more of the following:

- Impaired control over use of the drug
- Compulsive drug use
- Continued drug use despite harm
- Unmanageable drug craving

What is notable about this definition, and not unlike the DSM-IV-TR, is that the disease of addiction is essentially *behavioral* in nature. As Alan Leshner, former director of the National Institute on Drug Abuse, insightfully noted: “Addiction is not simply a lot of drug use; it is a disease of the brain that is expressed through behavior” [Leshner 1996].

In psychiatry, behaviors indicative of addiction are evident in diminished functionality across several life domains, including employment, family, social, and psychological. Impairments in these areas are similar to, or overlap with, those associated with poorly treated chronic pain.

Therapeutic progress in patients with addiction and in those with pain is measured in terms of overall decreases in disability and improvements in function. In that the clinical presentation of addiction and chronic pain coincide with respect to functional indicators, the recognition of addiction within the context of pain is challenging.

Inherent in this overlap is the concept that *neither pain nor addiction can improve if the other is left untreated*. Improved functioning due to pain interventions will not be evident if addiction continues to thwart recovery across life domains, and vice versa. Contributing to and further complicating chronic-pain conditions, opioid addiction often brings with it withdrawal-related hyperalgesia, sleep disorders, mood disorders, comorbid health conditions, increased risk for injury, and a general inability to comply with pain therapy regimens.

*Diagnostic criteria for opioid addiction are difficult to apply in the context of chronic pain and therapeutic opioid prescription.*

*“Addiction is not simply a lot of drug use; it is a disease of the brain that is expressed through behavior.”*

Thus, to adequately treat chronic pain in these patients, addictive disease must also be treated. Fortunately, the overlaps between addiction and chronic pain suggest that effective interventions for one disorder are also effective in treating the other. The successful management of chronic pain is enhanced by cognitive skills training, behavior modification techniques, social support, treatment of psychiatric comorbidity, and improved stress control. Thus, encouraging patients with chronic pain to avail themselves of these interventions also will prepare them for successful addiction treatment and recovery.

## Monitoring for Addiction

As with any chronic health problem, the best approach for managing addiction is *to monitor for it and be prepared for its emergence*. Similar to constipation and sedation, behaviors consistent with addiction may become evident during ongoing opioid use, and they should be assessed along with any other potential medication-related adverse effects. Known risk factors for addictive disease in the general population should be considered, such as a history of substance abuse (including alcohol and tobacco) in the patient or blood relatives, the presence of a psychiatric disorder, reported early-age onset of substance use (including alcohol), and a childhood history of physical or sexual abuse.

It is important to keep in mind that these are *only risk factors*, and multiple studies have shown that individuals with a clear history of successfully treated substance addiction are able to responsibly use analgesics for the management of pain without evidence of abuse. Early work from our clinic in patients with pain who did not meet current diagnostic criteria for substance abuse or addiction showed that 27% and 50% of them did have positive personal and family histories of addictive disease, respectively [Compton et al. 1998].

Carefully monitoring medication-use behaviors is critical to identifying the emergence of a substance-use disorder. As noted above, addiction is a disease of behavior, so the way a patient responds to the opioid-analgesic regimen provides important insights into the presence of addiction. Opioid treatment contracts, also called medication agreements, are extremely useful in this respect [Burchman and Pagel 1995; Doleys and Rickman 2003; Hariharan et al. 2007]. These documents clearly outline for the patient and practitioner the medication-use behaviors that are considered inappropriate and typically list certain drug-seeking behaviors that *may be* indicative of addiction.

These behaviors would include the use of multiple providers, repeated loss of medication, and repeatedly running out of medication early. Although they are not definite indicators of addiction, the presence of such aberrant behaviors alerts the practitioner to the fact that the patient is having difficulty adhering to the prescribed medication regimen, and those factors should be further explored.

An important, albeit imperfect, tool for evaluating medication-use behaviors in patients with chronic pain who are on opioid therapy is collecting from the patient random urine samples for toxicology analysis [Compton 2007]. This is a key component of the opioid treatment contract or medication agreement in that it provides objective evidence of medication-use behaviors; eg, the use of non-prescribed medications or illicit drugs or, conversely, the absence of the prescribed opioids can be detected. Neither the patient nor practitioner should view this as a punitive demand or evidence of mistrust.

Adopting a “universal precautions” approach [Gourlay and Heit 2005] to the collection of urine samples, and making it a part of treatment for *all* patients on opioid therapy, precludes con-

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cerns that certain patients are being targeted and can often uncover aberrant drug-use behaviors in seemingly compliant patients. Importantly, the aberrant behaviors identified via urine toxicology screens are not, by themselves, indicators of addiction, but they can call attention to potentially problematic medications and/or unauthorized substance use.

Thus, nonadherence to the treatment agreement or contract captures broad evidence of substance misuse but is not a sensitive indicator of addictive disease. Our investigations [Compton et al. in press] found that, although up to 28% of a sample of patients with chronic pain on opioid therapy were discharged due to medication-misuse behaviors (eg, urine toxicology positive for marijuana or cocaine, repeatedly running out of medications early, refusing to bring in remaining pills), far fewer discharges (8%) were due to the misuse of opioids in particular. Therefore, patient nonadherence to the treatment contract should be framed as a starting point or the basis from which to further evaluate the possible presence of addictive disease.

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## Assessing Addiction

There has been a recent flurry of evaluation tools and questionnaires in the literature designed to help the practitioner identify bona fide addiction [Butler et al. 2004; Compton et al. 1998; Manchikanti et al. 2004; Wu et al. 2006]. Consensus is building as to the strength of certain behaviors being more “suggestive of addiction.” Modeled after American Academy of Pain Medicine, American Pain Society, and American Society of Addiction Medicine guidelines [Consensus Document 2001], Savage conceptualized these behaviors as the “4 C’s” [Savage 2002]:

- ◆ Negative **Consequences** of medication use
- ◆ Loss of **Control** over use
- ◆ **Compulsive** use
- ◆ **Craving** or preoccupation related to medication use

She also emphasizes observation of behaviors that can be detected during the office visit, such as sedated appearance, excessive focus on opioid prescription, inability or unwillingness to provide a urine specimen, and problematic interactions with office staff. Additionally, other researchers have developed approaches to assessing potential opioid-use problems:

- In support of behavioral indicators, Chabal et al. [1997] focused on medication-related behaviors indicative of problematic opioid use: an overwhelming focus on opioids, using supplemental sources of opioids, patterns of early refills, multiple telephone calls relating to medications, unscheduled clinic visits, and/or episodes of lost or stolen prescriptions.
- Adding patients’ perceptions of their medication use, Adams et al. [2004] found that patients most likely to suffer addiction believe they need a higher dose of medication than was prescribed, report having difficulty getting the medication they need from the physician, and worry that they may be “too dependent” on the medication.
- Elements of each of the above are represented in the recent concept-mapping analysis of Butler and colleagues [2007]. They identify 6 factors significantly associated with current and future medication misuse (listed in order of importance): 1) noncompliance, 2) evidence of lying about drug use, 3) emotional/psychiatric issues, 4) poor medication response, 5) signs and symptoms of drug misuse, and 6) erratic appointment patterns.

Reports are lacking as to how well scores on these tools relate to the psychiatric diagnosis of a substance-use disorder. Thus, while they do provide more specificity in patient monitoring, they cannot be considered absolute evidence of addictive disease.

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We have found a functional evaluation of aberrant drug-use or medication-misuse behaviors to be quite useful in identifying patients with true addictive disease. In this approach (see **Figure** below), requests for more analgesic or drug-seeking behaviors are met with a careful re-evaluation of the pain symptoms, and new or additional potential sources of increased pain or discomfort are considered and addressed. Regardless of the findings, the patient’s complaints of pain are believed until proven otherwise, and the opioid dose is increased in an effort to improve relief.

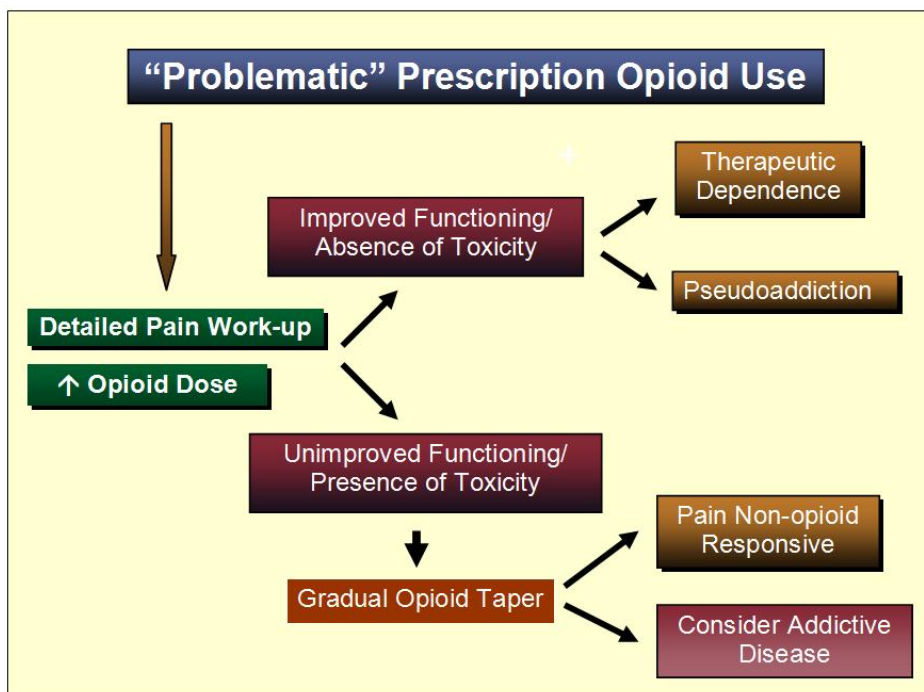


Figure adapted from Compton and Athanasos 2003; Weaver and Schnoll 2002.

If upward opioid dose titration is successful with respect to functional outcomes (ie, improved ability to participate in activities of daily life, fulfilling social roles, enhanced quality of life), it becomes evident that addictive disease is not an issue, as the presence of untreated addictive disease precludes improved functionality in the patient. Possible explanations for drug-seeking or aberrant medication-use behaviors in these patients include pseudoaddiction (drug-seeking secondary to undertreated pain [Weissman and Haddox 1989]), therapeutic dependence (drug-seeking secondary to anxiety about having an adequate supply of medication [Portenoy and Foley 1986]), or an untreated or poorly managed psychiatric disorder.

Alternatively, if the patient *does not* improve with increased opioid provision, the possible presence of addiction becomes more likely. An individual *addicted* to his or her pain medication will, by definition, be unable to control medication cravings and use, will continue using despite negative consequences (including the threat of discharge from pain treatment), and will often seek out new sources of more medication. In other words, with increased access to opioid

medication, addiction will ultimately be revealed, and pain will never be well-managed. A lack of functional improvement could also indicate that the patient suffers from a pain syndrome that is relatively non-responsive to opioid therapy, as with certain types of neuropathic pain. If the latter is true, tapering of opioids while alternative relief strategies are implemented should be relatively uneventful and even desired by the patient. If the patient is highly resistant to or unable to comply with the withdrawal of opioids, addiction may be motivating opioid use.

## Managing Addiction in Patients With Chronic Pain

Regular monitoring and thoughtful assessment of potential indicators of addiction in the patient with chronic pain form the cornerstones for its effective management. Once identified, the practitioner has the opportunity to *intervene in the progression of addictive disease*, thereby improving pain relief as well as general health outcomes. Unfortunately, a more common response to detection (or even suspicion) of addiction in a patient with pain is to discharge the individual from treatment, with perhaps a referral to an addiction-treatment program.

It is understandable that practitioners are motivated to “wash their hands of” these patients; for example, pragmatic concerns about the time/costs associated with treating these complex patients, perceived regulatory scrutiny, and patient noncompliance with the treatment regimen support terminating opioid therapy. Yet, summarily discharging these patients who may suffer an untreated and ultimately fatal disease (addiction) is, to this author, not only unethical but a source of significant harm.

Any time a medication is prescribed, it is the responsibility of the prescribers to have a working understanding of the potential adverse consequences of the pharmacotherapy. If they are unable to manage these adverse effects themselves, they should knowledgeably refer patients to qualified specialists who can better treat the untoward response.

In this sense, any practitioner prescribing opioids for chronic use should be accountable for having a management strategy in place if addiction should become evident. Providing daily opioids without suitable addiction expertise or support in place puts both the pain-management practitioner and patient at risk for poor outcomes.

Managing addiction within the clinical context of chronic opioid therapy prescribed for pain does not require the pain-management practitioner to become an addiction specialist. However, rather than discharging the patient, a thoughtful and working partnership between addiction and pain specialists should be developed, with the pain practitioner continuing treatment for pain while also playing a role in addiction treatment.

Merely discharging the patient with a referral for addiction treatment provides little opportunity for follow-up, and can result in both untreated pain and addiction. Few resources for referral exist with the necessary expertise and capabilities required to treat addiction within the context of opioid therapy for chronic pain, either in the pain- or addiction-treatment systems. Furthermore, adequate addiction treatment in the United States can be difficult and expensive to access, since public facilities often have waiting lists and insurance companies may dictate and capitate coverage for addiction services. For all of these reasons, it is incumbent upon the pain-management practitioner to take more of an advocacy role in the management of addiction, with the knowledge that doing so will ultimately result in better chronic-pain outcomes.

If addiction is strongly suspected, involvement of an addiction specialist or a formal treatment program should be considered. Some degree of substance abuse services are offered

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via insurance companies and Medicaid. However, rather than immediately sending the patient directly to an addiction-treatment program, it might be more appropriate to refer the patient to a psychiatrist for confirmation of the diagnosis.

If the patient does meet diagnostic criteria for a substance-use disorder, addiction-treatment strategies can be planned and implemented with input from the psychiatric consultant. Rather than discharging patients from opioid therapy at this point, the practitioner should make ongoing pain treatment contingent on active participation in addiction treatment.

Here are specific strategies that the pain-management practitioner can use to support and participate in treating addiction while continuing to address a patient's pain-relief needs:

1. While waiting for or after initiating addiction treatment, the patient should be frequently seen to monitor health and safety. In doing so, the practitioner can ensure that follow-up occurs with the addiction referral and can evaluate the degree to which the patient is engaged in treatment. This also provides an ideal opportunity to deal with the ambivalence the patient is likely to feel about considering addiction treatment.

Attendance at local 12-step program meetings can be very helpful at this time and continuing throughout treatment. These meetings are free and readily accessible in most communities, and most of them welcome patients with opioid problems (with or without alcohol problems). Encourage the patient to explore different meetings, as the subculture or milieu of each can vary, and it may take a few tries before a comfortable match is found. Attendance can help solidify a patient's commitment to stop addictive drug use, and most addiction-treatment programs use AA principles and groups to some degree.

2. An inability to control medication use is a cardinal sign of addictive disease, so, to support recovery efforts, the practitioner can assist the patient by putting controls in place with respect to opioid access. Opioids can be dispensed in smaller amounts and without refills, a responsible relative or friend can dispense the medication, and/or urine toxicology screens can be more strictly monitored. Controlled environments (eg, residential settings) help many drug-addicted persons cease aberrant drug use. The patient should understand that these controls are put in place to support addiction treatment and not to be punitive.
3. Once the patient initiates addiction treatment, the practitioner should become familiar with the addiction-treatment plan. Is it an outpatient program or residential? Are urine toxicology screens regularly assessed? To what degree are motivational, cognitive behavioral, and supportive services provided? Becoming knowledgeable about the expectations and interventions of the addiction-treatment program enables the pain-management practitioner to assess participation and progress, which should be noted in the patient's chart during each visit.
4. Addiction-treatment approaches relating to opioid prescription are of great concern to pain-management practitioners. Certain addiction-treatment programs refuse patients who are taking opioid analgesics and demand withdrawal of opioids as a part of therapy. In others, patients may receive a substitution opioid (eg, buprenorphine or methadone). In these cases, discussion of and agreement on the treatment plan by both the addiction- and pain-treatment practitioners are essential.

*Patients can find a great deal of useful information at the Alcoholics Anonymous website: <http://alcoholics-anonymous.org>*

*Including:*

- *links to listings of AA meetings in communities worldwide.*
- *listings of local telephone numbers for immediate access to information and assistance, and*
- *free downloads of various AA pamphlets and reading materials.*

Treatment for addiction does not necessarily prohibit the continuation of opioid medications for pain, if these are used responsibly and effectively. Often, a resistant addiction-treatment provider will be more willing to work with the patient on chronic opioid therapy if assured that the pain-management practitioner will continue to oversee pain treatment and help monitor the patient.

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5. Pain practitioners should take advantage of the Screening, Brief Intervention (motivational interviewing), Referral, and Treatment (SBIRT) initiative from the US Substance Abuse and Mental Health Services Administration [SAMHSA undated, see reference for URL link]. This helps train and provide reimbursement to general practitioners for engaging in addiction-related services in non-addiction-treatment settings. The federal government has developed two alphanumeric billing codes for these services to receive Medicaid reimbursement:

- ◆ H0049 Alcohol/Drug Screening – Alcohol and/or Drug Screening
- ◆ H0050 Alcohol/Drug Service Brief Intervention, per 15 minutes

Moving standardized addiction services into the general or pain practitioner's office is a landmark change in substance abuse treatment and is based on compelling data from multiple sources warning of the consequences of alcohol and drug addiction on the health of the US population. Motivational interviewing strategies employed in the office-based brief intervention will be useful for the practitioner for multiple situations in which behavioral change is indicated, such as with therapy for chronic pain.

6. The possible presence of psychiatric disorders (particularly depression and anxiety) should be evaluated, and pre-existing psychiatric disorders should be reassessed. Effective management of psychiatric disorders improves treatment outcomes for both addiction and chronic pain.

In that these patients are particularly complex, treating concurrent mood or anxiety disorders may be beyond the scope of practice for most pain-management practitioners, and referral to a psychiatrist could be warranted. If the patient is diagnosed with a psychiatric disorder, the pain practitioner should assess for symptoms on a regular basis and briefly note results of assessments in the patient's chart.

There are multiple screening tools available via the Internet for pain practitioners to use for assessments (see **Box**). Along with this, the practitioner should help ensure that the patient is involved in psychosocial services that might be available to patients with chronic pain, such as behavioral therapy and support groups.

- ◆ **Beck Depression Inventory:** <http://harcourtassessment.com/> (Enter "Beck Depression Inventory" in site search box.)
- ◆ **Center for Epidemiology Studies Depression Scale (CES-D):** <http://counsellingresource.com/quizzes/cesd/index.html>
- ◆ **Hamilton Anxiety Scale:** <http://www.cnsforum.com/clinicalresources/ratingscales/ratingpsychiatry/anxiety/>
- ◆ **State-Trait Anxiety Scale:** <http://www.mindgarden.com/products/staisad.htm>

## Conclusion

This *Current Comments* essay has emphasized that pain practitioners should become involved in, rather than draw away from, addiction treatment for their patients with chronic pain who have need for such services. The underlying premise is that by not managing active substance-use disorders as a part of the pain-care process, effective pain management cannot be achieved, and the chronic lethal disease of addiction will continue to progress.

### Key points include:

- There are inherent difficulties in defining and identifying addiction in patients with chronic pain, as the dysfunctions associated with poorly managed pain and addictive disease overlap.
- Careful and comprehensive monitoring for the emergence of addiction is obligatory in patients for whom chronic opioid therapy is prescribed.
- If medication-use behaviors, clinical observations, urine toxicology results, and decrements in daily function suggest that addictive disease is present, the involvement of addiction-treatment services in the pain-care plan is warranted.
- There is a scarcity of specialized treatment services for patients having both chronic pain and addiction, so it is necessary that the pain practitioner become an active participant in the management of concurrent addiction.
- Familiarity on the part of the pain practitioner with the addiction services a patient is receiving is essential for positive health outcomes.
- Specific strategies for the pain practitioner to use in helping to facilitate addiction recovery include: supporting the use of 12-step principles and programs, limiting opioid medication access, motivational interviewing techniques, and monitoring the patient for psychiatric comorbidity.

In summary, the partnering of pain-care and addiction-treatment providers – as opposed to merely discharging an opioid-addicted patient from pain treatment and uncertain follow-up with addiction-treatment services – provides increased support and resources for the management of both disorders. Thoughtful participation by pain practitioners in the care of their patients with addiction not only enhances therapy for chronic pain but provides the practitioner a unique opportunity to help stem the significant public health problem of opioid addiction.

*Participation by pain practitioners in a patient's addiction treatment provides a unique opportunity to better manage pain and help stem the significant public health problem of addiction.*

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