Opioids and Pain: Identifying, Assessing and Responding to an Aberrant Behavior

Contents

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Goal

The learner will be able to recognize aberrant behaviors that might suggest addiction or other substance misuse in chronic pain patients and take steps to distinguish between behaviors in terms of relative risk and distinguish undertreated pain from addiction/substance misuse.

After completing this module participants will be able to:

- Recognize aberrant behaviors in patients with chronic pain that might indicate substance misuse/addiction
- Monitor patients on chronic opioid therapy for substance use problems throughout treatment
- Distinguish among the various causes of aberrant behaviors and differentiate by severity
- Address aberrant behaviors appropriately through modifications in treatment

Professional Practice Gaps

Aberrant drug-related behaviors are seen in around 11% of patients on opioid therapy for chronic pain [1]. Current evidence-based guidelines, developed by the American Pain Society and the American Academy of Pain Medicine based on an extensive review of the literature, recommend specific screening and treatment responses for aberrant behaviors[2]. However, a 2004 national survey of 979 physicians for a report on diversion by the National Center on Addiction and Substance Abuse at Columbia University (CASA) identified a number of deficiencies in both competency and practice in related substance misuse practices[3]. The same survey found that the majority of physicians did not receive the necessary training, either in medical school or in CME[3].

INTRODUCTION

Contents for this module:

- Descriptions of aberrant behaviors that might signal substance use problems
- Distinguishing substance misuse from undertreated pain or mental health problems in patients exhibiting aberrant behaviors
- Rank aberrant behaviors by severity
- How to address aberrant behaviors due to **substance misuse** and **addiction**
- Providing **treatment structure** according to the **level of risk**
- Following **strategies to end chronic opioid therapy** when appropriate

MR. LEWIS - ABERRANT BEHAVIORS

Patient: Mr. Raymond Lewis, 72 y/o

Scenario: In earlier modules, Mr. Lewis was assessed for treatment of diabetic neuropathy that had not responded to first line treatments. He demonstrated moderate risk for opioid misuse; consequently, a little extra treatment structure was agreed to in the provider-patient agreement, such as a little more frequent appointments/smaller quantities prescribed. After a year, Mr. Lewis started asking for early refills on his opioid prescription. He did this several months in a row, each time a little sooner than the previous month.

Question: What are the possible reasons for Mr. Lewis's behavior? (check as many as apply)

1. Misunderstanding
    - Feedback: Possible. This is a common cause for misuse of opioids. The patient education checklist followed by a written Patient/Provider Treatment Agreement were used so misunderstanding seems less likely, but it is still possible. A careful interview and review of the agreement might give more information. If there is still doubt, urine toxicology, increased frequency of monitoring, and family interview with his permission are all possible ways to get more information.
2. Chemical coping
    - Feedback: Possible. Chemical coping is using the opioids to manage moods, anxiety, or stress. Given his history of addiction to an opioid many years ago and his history of depression, chemical coping is a possibility. A careful interview and depression screening might help provide more information along with urine toxicology, increased frequency of monitoring, and family interview with his permission.
3. Tolerance and physical dependence
    - Feedback: Tolerance possible but less likely/ Physical dependence possible and likely. Physical dependence is very common with chronic opioid therapy. Tolerance to pain effect is not a major problem with opioids but does happen.
4. Diversion
    - Feedback: Possible. Diversion is a possible explanation for aberrant drug-related behaviors. A careful interview, drug testing (is the prescribed drug missing in the urine because it was diverted?), followed by tightened treatment structure, such as unscheduled pill counts, if there are still doubts, is indicated.
5. Undertreated pain
    - Feedback: Possible. Undertreated pain is certainly a possibility. Diabetic neuropathy is a condition that often progresses and it has been a year since his prescription started. A careful interview with pain assessment and re-evaluation of the pain condition is indicated.
6. Pain coping
    - Feedback: Possible. The patient might need cognitive behavioral therapy to better cope with pain. A careful interview about his coping mechanisms is indicated.
7. Psychiatric comorbidity

- Feedback: Possible. Given his history of addiction to an opioid and of depression, psychiatric comorbidity is a possibility. A careful interview to screen for mental health problems is indicated.

8. Addiction
    - Feedback: Possible. Given his history of addiction to an opioid and of depression, addiction is a strong possibility. A careful structured addiction assessment plus interview might help provide more information along with urine toxicology, increased frequency of monitoring, and family interview with his permission.

ABERRANT BEHAVIORS DESCRIPTION

Aberrant Behavior Defined

Aberrant drug-related behavior refers to behavior outside of the societal norm and clinical expectations that may indicate substance misuse, abuse, or addiction, but may also indicate undertreated pain, misunderstandings, and a number of other problems discussed on the following pages.

Some level of monitoring aberrant behaviors should happen at each appointment. More formal monitoring with urine drug testing and assessment questionnaires can be used as needed according to risk level.

Any breach of a treatment agreement between the patient and provider during chronic opioid therapy is an aberrant behavior[4]. In addition to clear aberrant behaviors, there also may be multiple ambiguous behaviors that combine to increase the possibility of risk, such as several changes in work and social life that would be compatible with a substance abuse problem.

Three Levels of Drug Aberrant Behaviors

Level I: Relatively minor deviations that do not place the immediate health or safety of anyone in danger but can degrade the efficacy or treatment or the patient-provider interaction. Examples include:

- non-adherence to medication dosing
- non-adherence to other elements of the treatment plan
- attempts at early refills
- misplacing medications
- obtaining and distributing medications
- more than 3 Level I violations in a year are considered Level II

Level II: Continued violations of the treatment agreement that stem from severe psychological comorbidities. Patients who engage in Level II behaviors should be referred to a specialist in pain management, mental health, or addictions.

Level III: These are behaviors that are illegal, criminal, or dangerous. Cases of criminal diversion merit discontinuation of opioid therapy and referrals to regulatory authorities.

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MR. LOPEZ - PATIENT DIALOGUE

Name: Mr. Juan Lopez

Chief Complaint: Chronic Headache

History of Present Illness: The provider has been treating Mr. Lopez for chronic headaches with aspirin and oxycodone for the past 3 months. His pain was successfully managed under the initial treatment plan where he would take one or two 2.5 mg tablets as needed.

Patient Interview

Mr. Lopez: *I need the same thing, only stronger, because I've been having worse episodes almost daily where I need 3-4 tablets and then I run out early.*

Provider: *Okay. I need to know a little more so that I can more fully understand what's going on.*

Note that none of Mr. Lopez's aberrant behaviors so far were from the list deemed "severe." The provider next re-assesses Mr. Lopez's pain, pain condition, and substance use/abuse and reviews Mr. Lopez's pattern of pain medication use. Because there are several red flags for possible substance abuse (early refill, increasing his own dosage), before refilling Mr. Lopez's prescription, the provider also completed a more detailed assessment in order to determine if his need for an increased dose is related to undertreated pain rather than tolerance, diversion, or chemical coping.

[Provider continues the assessment:]

Provider: *How many times did you have to take 3-4 tablets?*

Mr. Lopez: *Every day for the past month.*

Provider: *The prescription I wrote would not cover that; did you obtain medication from somewhere else?*

Mr. Lopez: *Yeah, I got some from a friend and the free clinic, but they won't give me any more.*

Provider: *Are you always using the medication as directed?*

Mr. Lopez: *Yeah, most of the time. But I found it works better if I crush it and inject it.*

At this point, Mr. Lopez has exhibited two behaviors from the relatively severe list: obtaining prescriptions from multiple providers and crushing and injecting the drug and after completing the evaluation, the provider refers him to an addiction specialist for further evaluation.

LEVELS OF SEVERITY OF ABERRANT BEHAVIORS

Distinguish the Level of Severity of Aberrant Behavior

Aberrant behavior can be categorized according to severity based upon the underlying cause(s), context, and likelihood that it will recur[2]. Clinical responses based on severity are likely to be most effective. If the patient is stratified to a low-risk group, recommendations based on anecdotal evidence are that these patients may only need education and increased monitoring.

1. **Mild to moderately severe behaviors.** Mild to moderately severe behaviors include running

out early several times or unauthorized dose escalation[5]. Although not severe, they require further assessment to identify the reasons for the behavior and addressing the underlying cause. As previously noted, such behaviors might indicate inadequately managed pain, insufficient compliance with the treatment plan, or the need for more structure.

2. **Serious behaviors.** Serious behaviors, for example, pill crushing and injecting, obtaining multiple prescriptions from multiple sources, subjective sense of losing control, or repeated non-adherence to the management plan, requires a more directed response. For example, this may require a change to a less abused opioid, referral to an addiction specialist, and increasing the degree of treatment structure and change in patient agreement[2]. Although discouraged, discontinuing long-term opioid therapy may be necessary.

CASE: MR. ALVARADO PART 1

Patient: Mr. Bob Alvarado, 52 y/o

Scenario: Mr. Alvarado is a long-term patient who has suffered from lower back pain for 20+ years. He calls sporadically and asks for a refill. He reports that recent minor back injuries have exacerbated the problem and thus he has called for refills more frequently as of late. Longstanding back pain started with injury while moving furniture over 20 years ago.

Patient Interview.

Provider: Hi Mr. Alvarado, they told me that you asked to be fit in between appointments, because of an emergency. What's going on?

> **Mr. Alvaredo:** I'm not doing so good. I strained my back helping my nephew move. It's been flared up ever since. I've been having to take double doses daily and so I need more medication.

Provider: [Looking at Mr. Alvarado's record] But you didn't come to your last appointment, so you should have run out of medication over a month ago, especially if you're doubling up. How did you get enough for the double doses?

> **Mr. Alvaredo:** To tell you the truth, when you wouldn't give me a prescription without seeing me, I got one from Doc Smith. I just had to go pick it up so I didn't have to pay for an exam. But he said he'd only do it just the one time and I'm really hurting again today. I thought I'd just see if you could just write a prescription real quick. I'll just take a second of your time.

Provider: Remember the agreement we both signed that you would only obtain prescriptions from one provider and that you would make an appointment? These are important limitations that help me care for your pain safely.

> **Mr. Alvarez:** Yeah, I know, but I was in bad shape. One of the reasons I wanted to see you first is that there are some other treatments for a strained back that might help. I've tried all that. Believe me, none of it works when my back gets going.

Provider: Can you tell me more about what you've tried?...

Provider: *One of the reasons I wanted to see you before prescribing medications is that there are some other treatments for a strained back that might help.*

Mr. Alvarado: *I've tried all that. Believe me, none of it works when my back gets going.*

Provider: *Can you tell me more about what you've tried?…*

Question A: What aberrant behaviors, with respect to **appointment-related problems** or **irregular requests for medication**, does Mr. Alvarado display? (Check all that apply and click the "Next" button)

1. Walk-in visits in distress
    - Feedback: Correct. Mr. Alvarado showed up without an appointment and stated that he is in pain and has run out of his medication.

      If Mr. Alvarado were in your office, you would also note physical symptoms of distress, such as sweating, shakiness, or facial expressions.
2. Failure to keep appointments
    - Feedback: Correct. Mr. Alvarado missed one appointment.
3. Requests early refills; particularly with aggressive complaints about needing more
    - Feedback: Incorrect. Mr. Alvarado has not requested early refills.
4. Requests specific drugs, e.g., short-acting vs. long-acting preparations
    - Feedback: Incorrect. Mr. Alvarado has asked for more pain medication, but has not requested specific drugs.

Question B: What aberrant behaviors, with respect to **non-compliance** or **resistance to treatment**, does Mr. Alvarado display? (Check all that apply)

1. Not taking medications on the agreed upon schedule
    - Feedback: Correct. Mr. Alvarado has been doubling up on his medication and has not made an appointment for a refill as agreed upon.
2. Increasing his dose or combining use with other psychoactive drugs (including alcohol)
    - Feedback: Correct. Mr. Alvarado has been increasing his dose.
3. Unapproved use of the drug to treat symptoms other than pain or for other non-analgesic effects (sedation, increase energy, decrease anxiety, or intoxication)
    - Feedback: Probably Incorrect. Mr. Alvarado seems to only be taking the medication to treat his pain.
4. Increases dose without informing clinician
    - Feedback: Correct. Mr. Alvarado has been taking double the prescribed dose.
5. Drug hoarding during periods of reduced symptoms
    - Feedback: Incorrect. Mr. Alvarado has not displayed hoarding. He has run out of his medication because he is taking more than the prescribed dose
6. Disinterest in non-pharmacological treatments or failure to comply with these treatments
    - Feedback: Correct. Mr. Alvarado says that he has tried "all that."
7. Disinterest in physical or vocational rehabilitation
    - Feedback: Correct. Mr. Alvarado says that he has tried "all that."
8. Non-compliance with non-opioid treatments or evaluations

- Feedback: Incorrect. Mr. Alvarado has not yet tried non-opioid treatments or evaluations. These should be a part of any chronic pain treatment.

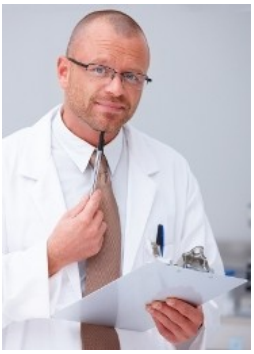
9. Unreasonable resistance to a change in therapy
    - Feedback: Incorrect. Mr. Alvarado is asking for more medication but so far has not demonstrated a resistance to a specific change in therapy. His statement, “I've tried all that. Believe me, none of it works when my back gets going" might come from a resistance to change or might simply be a statement of fact.

Question C: What **other aberrant behavior(s)** does Mr. Alvarado display? (Check all that apply)

1. Repeated reports of loss, stolen, or damaged medications
    - Feedback: Incorrect. Mr. Alvarado has not reported losing or having medication stolen.
2. Frequent ER visits in crisis
    - Feedback: Incorrect. Mr. Alvarado has visited at least one other provider to your knowledge to receive a prescription for pain medication, which is a concern, but there was no record of ER visits.
3. Illicit or non-prescribed psychoactive drug use, e.g., in urine
    - Feedback: Incorrect. Mr. Alvarado only reports taking prescription opioids. Urine drug tests have not yet been ordered.
4. Multiple prescribers (so-called "doctor shopping")
    - Feedback: Correct. Mr. Alvarado has visited at least one other provider to your knowledge to receive a prescription for pain medication.
5. Social isolation
    - Feedback: Possible. This needs to be explored. Mr. Alvarado reports helping his nephew; a full picture of his social support has not been established.
6. Reporting psychic effects not intended by the clinician.
    - Feedback: Incorrect. Mr. Alvarado has only reported analgesia from opioids.
7. He reports little analgesic effect from opioids.
    - *Feedback: Correct. Mr. Alvarado reports that his current prescription is not enough to help with his pain since the flair up with his nephew.*

DIFFERENTIATING CAUSES OF ABERRANT BEHAVIORS

Distinguish Motives and Behaviors



It is important to separate the "motive" from the "behavior" when dealing with pain and aberrant drug related behaviors.

One of the greatest challenges facing practitioners treating chronic pain is the attribution of aberrant behavior. Interpreting what this behavior means can be challenging; the differential diagnosis is varied and includes

- dependence,
- pseudoaddiction,
- addictive disease,
- comorbid psychopathology,
- "chemical coping,"

- or even criminal behavior (diversion).

REASONS FOR ABERRANT BEHAVIORS

Misunderstanding	Misunderstanding of proper use, such as attempting to treat other symptoms, taking multiple doses at once, or making mistakes due to cognitive impairment, is probably the most common cause of misuse[5]. Providing clear and written instructions and patient education is important to prevent this problem. It also helps to inform family and caregivers of the plan so they can ensure it is followed.
Tolerance and physical dependence	Patients who develop tolerance may require increased doses. Patients who are physically dependent may continue to use an opioid after acute pain is resolved due to withdrawal symptoms. Tolerance and physical dependence are normal in response to chronic opioid use and do not necessarily mean there is addiction[6].
Diversion	A small minority of patients seek prescriptions to obtain drugs that they sell or distribute to others. Additionally pills may be stolen from a patient with or without the patient recognizing that this has happened. Thus they may be genuine in not understanding where the pills went or they may be covering up for a family member with addiction or who is selling their medications.
Undertreated pain	may result in aberrant behavior that resolves if pain is treated properly; also known as pseudoaddiction[7].
Psychiatric comorbidity or need for emotional or behavioral support	Some aberrant behaviors may be due to: • Psychiatric comorbidity, e.g., mood or personality disorder. • Chemical coping, which is use of pain medication to cope with non-pain issues, such as unpleasant moods, sleep problems, or stress • Poor pain coping skills Referral for mental health counseling may be indicated in these situations. 5
Addiction	An addictive disorder may underlie drug-seeking aberrant behaviors, however, the rate of developing a full addiction for patients on chronic opioid therapy is fairly low[5].

NORMAL PHYSIOLOGICAL DEPENDENCE VS. ADDICTION

Dependence and addiction are not diagnoses in the current DSM 5 system (the current diagnostic term is "substance use disorder"), but they are still used informally. The important point is that addiction is behavior that goes beyond physiological dependence. It is possible to have physiological dependence whiled on chronic opioid therapy without being addicted. In fact, physiological dependence is experienced by nearly everyone on chronic opioid therapy.

While the terms “opioid dependence” and "opioid addiction" are often used synonymously, they are not the same[5]. Opioid dependence refers to a state in which the body requires exogenous sources of opioids to avert symptoms of opioid withdrawal[8]. It is anticipated that all patients on long term opioids become dependent on the medications[5]. In contrast, addiction refers to a primary condition in which a person experiences uncontrollable drug cravings, is unable to control their use of a drug, and continues to use the drug despite negative consequences[5,8]. A person can be addicted to opioids, which is currently known as opioid use disorder, but not be dependent on them, but this is not common. Likewise, a person can be dependent on opioids but not addicted to them, which is very common among patients who are on chronic opioid therapy[8].

Chronic Pain	***Addiction***
Controlled medication use	Poorly controlled medication use
Medication improves quality of life.	Medication does not improve quality of life or decreases it.
Willingness to decrease medication doses in response to unpleasant or dangerous side effects	Continues medication use despite unpleasant or dangerous side effects
Shows concern for cause of pain	Unaware or in denial about drug related problems
Follows treatment agreement	Has difficulty adhering to treatment agreement
Able to store left over medication	Repeatedly loses prescriptions; unable to store emergency medication supply

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ABERRANT BEHAVIOR OF ADDICTION

To determine the underlying cause of aberrant behaviors, it is important to rule out addiction, a psychiatric disorder. The criteria for determining if there is addiction are behavioral in nature.

DSM 5 Criteria for Substance Use Disorder (Current Version – Replaces DSM-IV TR Diagnoses Described Below)

The current version of the *Diagnostic and Statistical Manual of Mental Disorders* is the DSM 5, published in May 2013[10]. The DSM 5 combines the substance abuse and substance dependence diagnoses that were used in the previous version of the DSM, into one diagnosis: Substance Use Disorder. This is "a medical illness caused by repeated misuse of a substance or substances...characterized by clinically significant impairments in health, social function, and impaired control over substance use and are diagnosed through assessing cognitive, behavioral, and psychological symptoms"[11]. The other changes are that the criterion about legal problems was eliminated and a criterion about craving was added.

The new diagnosis, Substance Use Disorder, is graded according to severity based on the number of criteria met: 0-1: no diagnosis; 2-3: mild; 4-5: moderate; 6-7 severe[10].

Note that physiological dependence and tolerance in patients on chronic opioid therapy, should not be counted toward a diagnosis of substance use disorder.

If the criteria for substance use disorders are met, the patient should be referred for addiction treatment[12], as will be discussed.

ASSESSMENT TOOLS FOR ONGOING MONITORING

Ongoing monitoring for aberrant behavior of patients on chronic opioid therapy can be facilitated by using assessment tools designed for this purpose, such as the *Current Opioid Misuse Measure* (COMM), a 17-item self-report assessment of aberrant behavior[13] that has been well tested [2]. A more elaborate structured interview is another possible choice: the Prescription Drug Use Questionnaire (PDUQ) is a 42-question interview used to assess opioid abuse and dependence[14]; there is also a patient version of this tool, the PDUQp[15]. Another assessment in interview format is the ABC.

TOOL FOR MONITORING ABERRANT BEHAVIORS

The Pain Medication Questionnaire (PMQ)

Several validated tools exist for the monitoring of aberrant behaviors related to ongoing opioid prescription. The Pain Medication Questionnaire (PMQ) is described below as an exemplar tool for use in clinical practice[16]. Copyright owners will not permit us to show you the questionnaire within the module.

- The Pain Medication Questionnaire (PMQ) is an ongoing self-assessment tool that helps clinicians identify whether aberrant behavior of a patient on chronic opioid therapy is associated with opioid medication misuse.
- The PMQ identifies the evidence of *current* misuse in patients already on opioids.
- The PMQ should be used long-term, periodically throughout the patient's treatment.
- A high PMQ score indicates that a patient may be developing dependency or addiction to opioid pain medication. The clinician should address any addiction issues through treatment changes, referrals, or increased monitoring.
- Frequent use of the tool as a monitoring system should alert the clinician to early aberrant changes in the patient's behavior, and minimize the damaging effects of addiction in the patient's life.

Each ongoing assessment tool varies in terms of criteria, length, target population and context. Characteristics of the PMQ that make it appropriate for primary care practice include:

- Length: 26 items
- Time to Administer: 10 minutes or less
- Administered by: Self report
- Target Population: Adults
- Intended Settings: Primary care

The health professional should introduce the instrument to the patient, along with the reason for its use, and ask the patient to briefly and honestly answer the questions and mark their responses. Self-

administered tests like the PMQ may decrease the time needed to interview the patient, although they should never be a substitute for the clinician evaluating the patient through an interview process.

Scoring

The patient answers the 26 questions of the PMQ on a four-point scale of “Disagree” = 0, “Somewhat Disagree” = 1, “Neutral” = 2, “Somewhat Agree” = 3, “Agree” = 4). An overall score is derived by summing the item scores for the 26
questions. The minimum possible score is 0 (26 items × 0 points) and the maximum possible score 1s 104 (26 items × 4 points).

Interpreting the Results

Higher overall scores reflect behaviors more likely associated with risk for opioid misuse. Consider the following when interpreting results:

- Despite the numeric score, all patients with pain deserve to be treated.
- Clinicians should incorporate the results of the assessment into the patient's treatment plan as they see fit. This can include taking any of the following actions:
    - Referral to a specialist
    - Urine drug-screening
    - Increased monitoring of medication use
    - Discussion of alternative treatment
    - Further assessment
- High score results on ongoing assessment instruments should be used in documentation of treatment plan changes and justifying referral to a pain or addiction clinic.

Alternative Assessments

- For a more extensive assessment, try the PDUQp.
- If you prefer an interview format assessment, try the ABC.

MR. ALVARADO - ASSESSMENT

Name: Mr. Bob Alvarado, 52 y/o

History of Present Illness (repeated for convenience): Mr. Alvarado is a long-term patient who has suffered from lower back pain for 20+ years. He calls sporadically and asks for a refill. He reports that recent minor back injuries have exacerbated the problem and thus he has called for refills more frequently as of late. Longstanding back pain started with injury while moving furniture over 20 years ago.

Question: Select the best assessment tool for assessing Mr. Alvarado's recent aberrant behaviors from the following list:

1. CAGE alcohol misuse screening tool
    - Feedback: Incorrect. CAGE is a screening tool for alcohol use problems. Pain Medication Questionnaire is an assessment tool for ongoing monitoring of a patient on chronic opioid therapy for aberrant behaviors. Opioid Risk Tool is a screening tool for risk of opioid substance use problems.
2. Pain Medication Questionnaire (PMQ)

- Feedback: Correct for monitoring during chronic opioid therapy. Pain Medication Questionnaire is an assessment tool for ongoing monitoring of a patient on chronic opioid therapy for aberrant behaviors. Opioid Risk Tool is a screening tool for risk of opioid substance use problems.

3. Opioid Risk Tool (ORT)
    - Feedback: Correct. Opioid Risk Tool is a screening tool for risk of opioid substance use problems. CAGE is a screening tool for alcohol use problems. Pain Medication Questionnaire is an assessment tool for ongoing monitoring of a patient on chronic opioid therapy for aberrant behaviors.

ADDRESSING ABERRANT BEHAVIOR

Once aberrant behaviors are identified, it is important for the prescriber to address them. Below are outlined methods of addressing aberrant behaviors.

Communicate effectively about aberrant behaviors or positive urine drug tests.

Use empathy and a non-judgmental but straight-forward approach. For example, try introducing the problem lab result with "Help me to understand...." Describe limitations and acknowledge the patients' right to make their own decisions. Reassure them that their pain will be treated even if opioids are not a good choice for them.

Aberrant behaviors do not always mean addiction is present.

Identify the cause of the aberrant behavior and document it.

Examples of controls and limits to add include:

- counting their pills at each visit
- prescribing for shorter intervals
- conducting more frequent, random urine drug testing

Describe these changes in a written Patient/Provider Treatment Agreement. Note, some aberrant behaviors are more serious than others and deserve more of a response.

Tighten controls and limits on prescribing.

The changes needed in response to an aberrant behavior may be remembered as five items beginning with "S":

1. Limit **S**upply
2. **S**elect a drug with lower street value
3. **S**chedule more frequent visits and more frequent urine drug tests
4. Refer to a **S**ubstance Abuse Specialist

Discontinue opioids humanely, if indicated.

With severe or persistent aberrant behaviors, permanent tapering of opioids may be indicated[2]. The practice should have a protocol for how to discharge patients from the practice when necessary, including:

- notification in writing
- attempting to refer the patient for substance abuse treatment if addiction is the likely cause of the aberrant behavior
- instructions on how and where to obtain medical care in a timely manner

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	To minimize discomfort and manage withdrawal, treatment by an addiction specialist is strongly suggested[2]. Providers must be trained and certified in the use of the opioid agonist methadone or partial agonist buprenorphine for the treatment of opioid use disorder[2].
Consult/refer for specialty treatment.	Consider consultation and referral with a pain specialist, psychiatrist, or addiction medicine specialist

MR. ALVARADO - MANAGEMENT

Name: Mr. Bob Alvarado, 52 y/o

Summary of History of Present Illness:

- Long-term patient, lower back pain 20+ years (injury moving furniture)
- Calling more frequently for refills

You've become concerned about Mr. Alvarado's increased requests for refills.

Question As part of ongoing management, which adherence monitoring tool(s) would you choose to use with Mr. Alvarado? (Check all that apply)

1. Assess mood/affect/mental health status
    - Feedback: Correct. Mental health problems are common when there are substance use problems, particularly depression and anxiety, and these should be addressed if present.
2. Urine drug testing
    - Feedback: Correct. Urine drug testing for the specific drug prescribed will help you determine Mr. Alvarado's adherence to the treatment agreement if you are wondering whether he is taking his medication; you can also test for illicit substances.
3. Small prescription size/more frequent visits; making each prescription contingent on adherence to treatment agreement
    - Feedback: Correct. Small prescription size with more frequent visits and making the prescription contingent upon following the treatment agreement will support Mr. Alvarado in using his medication as prescribed.
4. Pill counts
    - Feedback: Correct. Requesting pill counts supports Mr. Alvarado in using his medication on schedule.
5. Interviews with significant others or persons in a position to report on the patient's behavior
    - Feedback: Potentially correct. With appropriate permissions, involving family can help provide a closer look into his compliance with the treatment plan, and can help Mr. Alvarado by engaging social support.
6. Prescription Drug Monitoring Programs
    - Feedback: Correct. Prescription drug monitoring programs should be checked to find out how many other prescriptions he has obtained.
7. Referral for psychiatric treatment
    - Feedback: Potentially correct. If Mr. Alvarado shows signs of possible mental health problems, such as depression or anxiety, and treatment or assessment are outside of

your expertise, a referral for psychiatric evaluation might be indicated, but the need for psychiatric treatment is not clear at this time.

8. Referral to addiction treatment
    - Feedback: Potentially correct. If Mr. Alvarado does not respond to tightened treatment structure or further assessment suggests addiction, referral to addiction treatment would be indicated.

SUMMARY

Here is a summary of **recommended** skills, organized by provider core competencies:

Provide patient-centered care

- Communicate effectively with patients about problematic medication use; use a sensitive, non-judgmental approach when discussing possible substance abuse/misuse/addiction.
- Clearly inform patients about circumstances in which opioid therapy would be discontinued before pain treatment begins, and stick to the consequences (e.g., discontinuation of prescribing of opioid therapy).
- Strategies for discontinuing opioid therapy must be made on an individual basis.

Work in interdisciplinary teams

- Make appropriate referrals to mental health treatment, such as cognitive behavioral therapy, for support in coping with pain, as a part of the multi-modal treatment plan.
- When the source or complexity of the patient's aberrant behaviors is beyond the skills or resources of the evaluating provider, consultation with or referral to specialists are indicated. The specialist may be a pain specialist, psychiatrist, or addiction medicine provider.

Employ evidence-based practice

- Distinguish among aberrant behaviors that are due to misunderstanding of proper use, chemical coping, inadequate pain management (pseudoaddiction), tolerance, physical dependence, diversion, pseudoaddiction, poor pain coping skills, psychiatric problems, or addiction. This will more clearly identify patients that may indicate substance abuse/misuse/addiction.
- Always at least consider aberrant behavior due to an undiagnosed medical cause (for example, the chronic back pain patient with an undiagnosed metastatic spread to bone of prostate cancer).
- Distinguish between relatively low versus high-risk aberrant behaviors.
- Address aberrant behaviors due to substance abuse and addiction via appropriate treatment modifications:
    - Provide treatment structure according to risk level; tighten controls and limits on prescribing, as needed.
    - Follow strategies to end chronic opioid therapy when appropriate; wean the patient off the opioid and detoxify as needed.

    - Consult/refer for specialty treatment with follow-up.
- Continualy monitor pain patients using various assessment tools to detect aberrant behaviors, drug-seeking behaviors, or noncompliance.
- The Pain Medication Questionnaire (PMQ) is a clinical tool that can be used for ongoing monitoring of aberrant behaviors in patients receiving chronic opioid therapy.

APPLY QUALITY IMPROVEMENT

- Recognize aberrant behaviors in chronic pain patients that might indicate substance abuse/misuse/addiction, such as requests for early refills, noncompliance with medication instructions, and treatment resistance.
- Assess and document critical outcomes (5 "A"s: Analgesia, Activities, Adverse effects, Aberrant behaviors, and Affect) at every visit during ongoing pain management. Adherence to treatment agreement, if there is one, is another "A" that can be evaluated.

UTILIZE INFORMATICS

- Efficiently document evidence of possible substance abuse/misuse/addiction in the patient record.
- Review your medical record system to search for ways to better support regular monitoring and tracking of aberrant behaviors of patients on chronic opioid therapy.
- See the Key Info Guide on assessment instruments, located on this website, for more information on ongoing monitoring tools.

RESOURCES AVAILABLE THROUGH THIS MODULE:

- ABC: Addiction Behaviors Checklist
  An assessment checklist that screens for characteristic addictive behaviors in chronic pain patients prescribed opioid medications.
- Development and Validation of the Current Opioid Misuse Measure
  Measure of opioid dependency and addiction for patients already on long-term opioid therapy. Authors: Butler SF, Budman SH, Fernandez KC, Houle B, Benoit C, Katz N, Jimison RN Title: Development and Validation of the Current Opioid Misuse Measure
- DSM 5 Substance-Related and Addictive Disorders
  The APA's breakdown on changes to substance-related addictive disorder diagnoses introduced by DSM-5. The document goes over substance use disorder, addictive disorders and briefly states the APA's position on caffeine use disorder.
- PDUQ: Prescription Drug Use Questionnaire
  An interview format yes or no questionnaire administered by the clinician and designed to detect prescription pain medication addiction in chronic pain patients. (Located at the end of article) Authors: Compton P, Darakjian J, Miotto Karen
- PDUQ: Prescription Drug Use Questionnaire (Self-Report)
  A self-report questionnaire for the screening of opioid use and dependency in patients with chronic pain. Authors: Compton PA, Wu SM, Schieffer B, Pham Q, Naliboff BD. Title:

Introduction to a self-report version of the Prescription Drug Use Questionnaire and relationship to medication agreement noncompliance Issue: 36(4):383-95.

- PMQ: Pain Medication Questionnaire
  Screening tool used to accurately identify chronic pain patients that are at risk for opioid dependency or abuse. This article examines the predictive validity of the PMQ in risk assessment. Authors: Dowling LS, Gatchel RJ, Adams LL, Stowell AW, Bernstein D Title: An evaluation of the predictive validity of the Pain Medication Questionnaire with a heterogeneous group of patients with chronic pain. Issue: 3(5): 257-66.

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