Expanded Skills - The High Risk Patient and Opioids

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EXPANDED SKILLS: THE HIGH RISK PATIENT AND OPIOIDS

Goal:

Prescribing clinicians will intensify treatment structure as needed for patients on chronic opioid therapy when there is higher risk of substance abuse.

After completing this module participants will be able to:

- Triage patients needing chronic pain treatment who are at high risk for substance use problems to appropriate level of care (stratify risk)
- Modify treatment for patients needing chronic pain treatment who are at high risk for substance use problems
- Form a pain treatment agreement with intensified treatment structure for patients who are at high risk for substance use problems
- Address breaches in the pain treatment agreement

Professional Practice Gaps

Non-medical use of opioids is high: an estimated 4.9 million people over age 12 have used opiate pain medication in the past month, according to the 2012 National Survey on Drug Use and Health, which represents a slight increase from the previous year[1]. The guidelines for prescribing opioids produced by the CDC recommend at least a baseline and periodic drug screening of urine and checking of the prescription drug monitoring data base for all patients being prescribed chronic opioids[2]. Providers need to intensify that treatment structure when risk of substance misuse is identified when screening patients for chronic opioid therapy, according to guidelines developed by the American Pain Society and the American Academy of Pain Medicine based on an extensive review of the literature[3]. After initiating chronic opioid treatment, physicians should continue to monitor patients on chronic opioid therapy using assessment/tracking tools, urine drug tests, prescription drug monitoring at a higher rate and add additional structure such as pill counts and more frequent visits[3,4]. This is particularly important when treating the patient with high risk for addiction/misuse. However, a national survey of physicians revealed multiple deficits in the skills needed to provide the necessary monitoring[5]. The majority of physicians surveyed indicated they did not receive adequate training in this area. CASA concluded that physicians should receive more continuing medical education related to prescribing and administering controlled substances and identifying, diagnosing, and treating substance abuse and addiction[5].

INTRODUCTION: HIGH RISK PATIENT

Contents for this module:

- Stratify patients on chronic opioid therapy to the most appropriate level of care according to risk for substance misuse
- Develop a treatment plan and monitor patients on chronic opioid therapy according to the level of risk for substance misuse

- Increase treatment structure for patients on chronic opioid therapy who are at high risk for substance misuse
- Modify chronic opioid therapy and tighten treatment structure for patients at different stages of recovery
    - Past history of substance misuse
    - In treatment/recovery
    - Active substance misuse
- Respond to aberrant drug-related behaviors in patients on chronic opioid therapy

At the end of this module, we will ask you to set some goals for your practice based on what you learn in this module.

The following case is presented throughout this module, providing you an opportunity to practice clinical applications:

Case Introduction: Mrs. Regina Banks, 42 years old

Brief History: Mrs. Banks is on NSAIDs for a frozen shoulder that has been bothering her for 5 weeks. She had been self-medicating with "some old pills I had lying around", because the NSAIDs "don't even touch" the severe, constant pain. She ran out a week ago and asked for a prescription for oxycodone. She was formerly addicted to prescription opioids after a previous episode of frozen shoulder on the other side 10 years ago. She says that she had been in recovery for 5 months when this current condition arose.

STRATIFICATION BY RISK

Stratification by risk means using the patient's risk level, determined during their assessment, to select a practice setting for the patient and level of treatment structure they need including the intensity of patient monitoring. Factors putting a patient in a high-risk category include:

Characteristics of High-Risk Group

- Personal and/or family substance abuse history
- Active addiction or current illicit use
- Major untreated mental health problem
- Isolated, dysfunctional social environment
- No satisfying work, recreation, or other activities

Disposition of the Patient by Risk Level

1. **Low risk**: manage in primary care
2. **Medium risk**: refer/consult with specialists, followed by co-management between primary care and the specialists
    1. Consultation with specialists in pain medicine, addiction medicine, and/or counseling may be needed for assistance with assessment or stratification of risk, depending upon the expertise of the provider and the complexity of the case. For example, consultation should be considered with a history of addiction, a comorbid psychiatric disorder, or other risk factor for addiction/substance abuse.

2. Obtain release of information with any and all providers you refer or consult with to allow open communication to better care for your patient

3. **High-risk**: Refer to pain/addiction specialists. Determine which type of pain or addiction specialist is appropriate:
    1. Consider referring patients who develop a chronic pain syndrome, such as complex regional pain syndrome or central pain syndrome, to a pain specialist.
    2. Refer patients who have an addiction disorder for addiction treatment.
    3. Refer patients to other medical and mental health specialists when appropriate.
    4. Refer chronic pain patients who require opioid therapy and have "yellow flags" for addiction to a pain specialist with expertise in addiction or a combination of appropriate specialists.
    5. Include all key patient information (history and current status) in referral report.
    6. Obtain release of information with any and all providers you refer or consult with to allow open communication to better care for your patient

KEY POINTS

- Use assessed risk level (stratification of risk) to determine patient's disposition and level of structure when treating chronic pain with controlled substances.
- Know patient's disposition by risk level whether low, medium, or high.
- Consider consultation or referral to specialists with medium risk patients.
- Choose from a spectrum of choices incorporating pain/addiction specialists with high risk patients.

FYI

"There are no randomized trials or controlled observational studies on the benefits and harms of opioid for chronic noncancer pain in patients with a history of substance abuse or addiction that are undergoing treatment for addiction" [6].

FREQUENCY OF MONITORING

Monitoring in Higher Risk Patients

- **Moderate risk +/- dose of opioids not stable**

  More frequently than monthly at first, then more frequently than every three months, with the frequency being based on severity of risk.

- **Very high risk**

  Weekly monitoring

- **High doses of opioids or frequent dose escalations**

  Doses that are the equivalent to 200 mg morphine per day or greater and/or frequent dose escalations require more frequent monitoring

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The level of treatment structure for high-risk patients, if you continue to treat them yourself, is described in the following pages.

TREATMENT BY RISK LEVEL

Match Structure of Care to Risks

The structure of care should match risk with treatment boundaries and intensity of structure. This is discussed further in another module.

Five aspects of treatment structure need to be addressed in adapting care to match the level of risk[7]:

1. **Setting**

   Setting of care (primary care versus specialty care; clinical care team membership);

2. **Selection**

   Selection of treatment (risk/benefit assessment of specific medications and treatments);

3. **Supply**

   Supply of medications (controls on and amounts of medications dispensed);

4. **Supports**

   Supports for recovery (implementation and documentation of recovery activities)

5. **Supervision**

   Supervision and monitoring (frequency of visits, urine toxicology screens, pill counts, other)

These five aspects of treatment structure are discussed in greater detail for high risk patients on the following page.

KEY POINTS

- Modify the following treatment structure areas to address risk[7]:
    - Setting of care
    - Treatment selection
    - Amount of medication dispensed
    - Recovery activities
    - Monitoring visits

A PLAN FOR HIGH RISK PATIENTS

Treating and Monitoring

When treating patients with high risk, precautionary measures must be taken to establish a baseline[3].

Review of precautions with high risk patients for chronic non-cancer pain treatment.

Treating and monitoring for the high risk patient (Variables starting with "S"[7])

Setting of care

- Patients actively using illicit drugs are not good candidates for long term opioid therapy, unless in a highly controlled setting, such as a treatment program and while being directly observed[3].
- Consult with addiction and mental health specialists when there is an addictive disorder or significant mental health disorder (if necessary, via telemedicine or web-based resources[3].
- For patients who do engage in aberrant drug-related behavior, consider restructuring the therapy, referring to a specialist, or discontinuing long term opioid therapy ([3] – strong recommendation, low-quality evidence).
- Coordinate care optimally through assigning provider to this role of "patient home."

Selection of treatments

- Avoid opioids in pharmacologic treatment (Webster & Dave, 2007); minimize reward[7]
- If opioids are required, use tamper resistant, especially if they have a history of IV drug use or snorting their medications[8]. Avoid rapid onset and limit short-acting. Use an opioid that has relatively lower frequency of abuse in the community if possible.
- Use non-pharmacologic treatment–employ physical, psychobehavioral, procedural, and non-opioid medication interventions[8].

Supply of medications

- Shorter intervals between prescriptions/limited prescription quantities --weekly to monthly at first; some may require more smaller quantities at a time
- Steady state might be best for some patients as opposed to "as needed"
- Consider using third party control of opioids[8]

Supports for recovery

- Required participation in counseling or support group, such as a 12 step program or psychiatric care if needed. Considerations: ask for documentation, have patient get sign off of meeting attendance, request patient get a sponsor, request the patient “joins a group”
- opioid maintenance for relapsing opioid addiction; if this is a different provider, sign releases and work with them as part of the treatment team
- multidisciplinary pain care

Supervision and monitoring

- Periodic actions to confirm adherence to the opioid plan of care ([3] -- strong recommendation, low-quality evidence).
- Increased frequency of office visits
- To tighten structure of monitoring, increase frequency and intensity of monitoring activities[3], at least some randomly.
    - urine drug testing
    - pill counts
    - ask about proper use at each appointment
    - obtain collateral information from significant others
    - periodic review of prescription drug monitoring
    - pain and medication diaries
- Increased frequency of assessing for addiction, abuse, and chemical coping using a tool appropriate for chronic pain patients, such as the PDUQ, COMM or similar
- Patients requiring repeated dose escalations or high doses should also receive increased monitoring (when dose reaches the equivalent to 200 mg morphine per day)[3]

When structured care fails, opioids can be provided within addiction treatment (methadone maintenance or buprenorphine)[7]. Otherwise, opioids need to be tapered and alternative pain care provided.

MRS. BANKS - TREATMENT AGREEMENT

Patient: Mrs. Banks - 42 years old

Chief Complaint: Pain from "frozen shoulder"

History of Present Illness Summary:

- Currently taking NSAIDS for pain, and "old pills lying around" for severe pain
- Formerly addicted to prescriptions opioids for similar pain (2 years ago)
- Asking for oxycodone prescription

Urine toxicology: Positive for opioids

Patient Interview

Provider: *Your urine test showed that you've taken opioids in the past few days. Can you tell me about that?*

Ms. Banks: *I might have found a pill or two in my boyfriend's bathroom. But that's all.*

Provider: *I'm concerned that, with your history, prescribing opioids for you may be risky.*

Ms. Banks: *But nothing else works!*

Provider: *If we're going to work together, there will have to be an agreement we both sign that provides lots of structure to help keep you from becoming addicted again. Part of that agreement is that you'll have to be open and honest with me about what you're taking so that I can take care of your pain effectively and safely. Are you willing to work with me on that?*

Ms. Banks: *Sure, whatever it takes. I'm no addict. Not anymore.*

Question 1: Which of the following accurately describes an element of a treatment agreement and how it needs to be structured in order to provide Mrs. Banks with the support she needs? (Check all that apply)

1. Require participation in a support group
    - Feedback:
    - Given her history of addiction and recovery for less than a year, a support group is a good support for continued recovery.
2. Amount of medication dispensed should be for only one to two months at first.
    - Feedback:
    - Weekly quantities at first are recommended.
3. Avoid use of opioids if possible
    - Feedback:
    - Alternative methods of pain management should be used if effective.

4. Urine drug testing
    - Feedback:
    - Urine drug testing will help confirm adherence to the treatment plan.

Question 2: Which of the following are things you can do to confirm Mrs. Banks's adherence to the opioid plan of care? (Check all that apply)

1. Urine drug tests
    - Feedback:
    - Correct. With a urine drug test, you can determine if she is taking opioids of the prescribed type if you request that test specifically. Also, you can determine if she is abusing other classes of substances.
2. Pill counts
    - Feedback:
    - Correct. With a pill count, you can tell if she is running out of her drug supply too early which may indicate she is taking too many or she is diverting the medication.
3. Asking about proper use at each appointment
    - Feedback:
    - Correct. Simple, direct communication is sometimes the most effective means of detecting substance abuse problems.
4. Obtaining collateral information from significant others
    - Feedback:
    - Correct. Obtaining collateral information from a significant other can be useful if you know that you can trust them.
5. Prescription drug monitoring reports
    - Feedback:
    - Correct. Prescription drug monitoring reports will let you know if she is obtaining similar prescriptions from other doctors.

Question: How frequently should Mrs. Banks be scheduled for follow-up?

Best answer: Every few days at first

- Feedback: Correct
- Because Mrs. Banks is high risk for substance abuse, see her every few days at first and only prescribe enough medication for that time period plus a couple of days. Request that she bring the pills to the next appointment to see if she can adhere to the treatment agreement.

RESPONDING TO ABERRANT BEHAVIORS

Aberrant behaviors were covered in detail in another module. Examples of relatively higher risk aberrant behaviors include the following:

- Repeatedly missed medical appointments with you or with other providers to which you referred the patient for underlining pain issues
- Repeated requests for early refills: lost or damaged medications

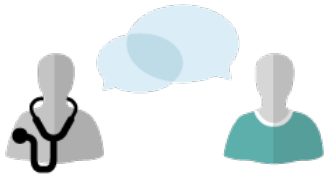
- Pharmacy issues: repeated early refill requests, obtaining multiple prescriptions from multiple prescribers
- Taking the medication by an alternative route, e.g., crushing and injecting
- Any other repeated non-adherence to the treatment agreement

GUIDELINES

In response to aberrant drug-related behavior: Consider restructuring the therapy, referring to a specialist, or discontinuing long term opioid therapy ([3] -- strong recommendation, low-quality evidence).

1. Communicate Effectively

Key elements include:



- Non-judgmental attitude
- Honest, straight-forward, complete communication including discussion of appropriate boundaries and limitations. (Describe the responsibilities and expectations of the patient.)
- Empathy for difficulties
- Acknowledgment of their right to make their own decisions
- Reassurance that their pain will be treated even if opioids are not a good choice for them. (Acknowledge the responsibilities of the provider.)

Motivational Interviewing (MI) is an approach to communicating with patients that is effective in facilitating health behavior change, particularly addictive behavior[9]. It includes many of the factors described above and additional strategies. For example, when encountering resistance from the patient, MI recommends "rolling with the resistance" that is agreeing with the patient rather than trying to talk him/her out of it. An alliance is formed with the patient, rather than a provider/dependent relationship.

2. Document Aberrant Behavior/Lack of Adherence

Document substance abuse in the patient's medical record, including type, quantity, and duration of substances used. Document any other non-adherence to the prescribed treatment or treatment agreement. Be aware that there may be other reasons besides addiction for aberrant behavior, including misunderstanding of proper use, chemical coping (using one's medication to cope with life), pseudoaddiction (behaviors due to undertreated pain), diversion, psychiatric comorbidity as described in the module on aberrant behavior.

3. Tighten Controls and Limits on Prescribing

Possible ways to tighten controls and limits on prescribing include:

- Pill counts
- Prescribing for shorter intervals.

  Use the "Do not fill until" option on the prescription to provide up to a 90 day supply of medications in small quantities at a time, which prevents the patient from taking pills early. Put date of issue on the prescription in the usual place. Add, "Do not fill until (insert date)" in the lower right hand corner.

- Involving a trusted third party to dispense the medication
- Written treatment agreements.

  Written treatment agreements can be initiated at this point or, if already in place, revised in accordance with the tightened structure. If not already stated, having negative urine drug tests and appropriate pill counts can be required to continue on the prescribed medication. The written agreement may require urine and serum medication level screening when requested, describe the number and frequency of all prescription refills, and describe the reasons for which drug therapy will be discontinued if these are not already described[10]. Discontinuation should be with appropriate tapering.

4. Provide Behavioral Interventions

Brief behavioral interventions, in the form of cognitive behavioral therapy, in conjunction with close monitoring as described above, were effective in reducing misuse in one study of high-risk patients on chronic opioid therapy[11].

5. Discontinuing Opioids Safely When Indicated

Temporary or permanent tapering of opioids may be needed. Discontinue opioids when there are diversion or serious aberrant behaviors, e.g. injecting an oral preparation[3]. Taper or detox humanely and manage withdrawal or refer for this purpose[3].

6. Consult and/or Refer for Specialty Treatment

When the complexity of the patient's situation is beyond the skills or resources of the evaluating provider, a consultation and possibly a referral are indicated. Patients who have misuse problems that do not resolve with tightened structure or possible addiction should also be referred for specialty treatment. Co-management with a specialist might be a possibility for some of these patients.

MRS. BANKS - COMMUNICATION

Ms.Banks

Review Patient Information:

Patient: Mrs. Regina Banks - 42 years old

Chief Complaint: Pain from "frozen shoulder”

History of Present Illness Summary:

- Currently taking NSAIDS for pain, and “old pills lying around” for severe pain
- Formerly addicted to prescriptions opioids for similar pain (2 years ago)
- Asking for oxycodone prescription

Mrs. Banks missed two appointments and then returned and the urine toxicology report showed opioids in her urine.

Patient interview

Provider: *[Following the recommendation to discuss aberrant behavior openly with patients] Hi, Mrs. Banks. Well, your urine toxicology tests show you've been taking opioids recently, but the prescription I gave you ran out 2 weeks ago.*

Ms. Banks: *Yeah, I got some from the clinic in my boyfriend's neighborhood because I was staying over there.*

Provider: *Mrs. Banks, I want to help you, but in order for us to work together you have to stick with the treatment agreement we both signed. And that included only obtaining your medication from this office and keeping your appointments.*

Ms. Banks: *I'm sorry. Like I said, I was staying over there. But I'm back and I'll just come to you from now on.*

Provider: *This is the second problem that has come up, so I'm going to need you to show you're ready to work together on this and keep to our agreement by coming back in a couple of days. Will you do that?*

Ms. Banks: *If that's what I've got to do.*

Question: Which communication steps did the provider effectively demonstrate with Mrs. Banks? (Check all that apply)

1. Non-judgmental attitude
    - Feedback:
      Correct. The provider remains objective and is not judgmental.
2. Honest, straight-forward, complete communication including discussion of appropriate boundaries and limitations. The responsibilities and expectations of the patient were described.
    - Feedback:
      Correct. The provider is straight-forward and clear.
3. Empathy for difficulties
    - Feedback:
      Incorrect. The provider did not offer words of empathy when addressing Mrs. Banks's situation. Doing so would improve rapport.
4. Acknowledgment of Mrs. Banks's right to make her own decisions
    - Feedback:
      /Correct. The provider presented Mrs. Banks with the choices available to her.
5. Reassurance that her pain will be treated even if opioids are not a good choice for her. (Acknowledge the responsibilities of the provider.)
    - Feedback:
      Incorrect. The provider does not specifically state that Mrs. Banks's pain will be managed whether or not opioids are used. Doing so would make the relationship more egalitarian.

PATIENTS WITH HISTORY OF SUBSTANCE MISUSE AND PAIN

With appropriate monitoring and treatment structure, opioids can be used to manage pain in patients with a history of substance misuse[12]. The goal is to minimize the risk and effects of relapse as well as to develop a support network. Some reports have indicated that opioid therapy is more successful in patients whose substance use disorder is more remote[13].

It is important to inform the patient of the possibility of dependence and what that means, as you would with any patient placed on chronic opioid therapy.

Assessment

A comprehensive, careful history needs to be obtained from patients in recovery who require treatment for pain. Assess their risk for relapse, including the usual assessment for risk factors for substance misuse that is used with all patients being considered for chronic opioid therapy (See the module on assessment). Additionally ask about the following[14]:

- How long they have been in remission
- How long since treatment or are they still in treatment
- Attendance at 12 step meetings, such as AA
    - Do they attend regularly?
    - Do they have a sponsor and is the patient in touch with them?
- Support system
- Current work status
- Current environmental stressors

In addition to pain evaluation and history, this history should include:

- Prior medical history
- Current physical and emotional health
- Details of recovery
- Review of all the medications being taken. This can be done through patient interviews, urine drug testing, prescription drug monitoring, contacting previous provider(s). Keep in mind sources of urine drug test false positive results, for example, herbal medications can result in false positive results[3]. See the module on urine drug testing.
- Comorbid psychiatric conditions. Comorbid psychiatric conditions are common in chronic pain patients with a history of addiction, especially depression, anxiety disorders, and personality disorders. Both psychological and physical factors contribute to pain; therefore, identifying and treating the psychiatric component can decrease the severity of pain as well as increase treatment adherence[3].

KEY POINTS

- Obtain a comprehensive medical history for patients with history of substance misuse who have chronic pain.
- Use additional patient monitoring and treatment structure when prescribing opioid prescriptions to manage pain in patients with a history of substance misuse.
- Recommend steps to develop the patient's support network, such as participation in a 12-step program.

POLL: PATIENTS WHO ARE IN SUBSTANCE ABUSE TREATMENT CAN SAFELY HAVE THEIR PAIN TREATED WITH OPIOIDS

Poll Responses:

1. Strongly Agree
    - 6% (33 votes)
2. Agree
    - 36% (205 votes)
3. Neutral
    - 32% (182 votes)
4. Disagree
    - 20% (115 votes)
5. Strongly Disagree
    - 5% (30 votes)

Total votes: 565

PATIENTS IN TREATMENT/RECOVERY

Treatment Considerations

Avoid medications that can trigger relapse

- *Use non-opioid pain therapies first.* As with treatment for pain patients with active substance abuse, physicians should first try to manage pain in patients in recovery from substance abuse with non-opioid pain therapies and also avoiding other scheduled substances[12], including:
    - NSAIDs
    - antiepileptics
    - biofeedback
    - electrical stimulation
    - acupuncture
    - behavioral therapy

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- Avoid medications that can trigger relapse including the muscle relaxant carisoprodol, the barbiturate butalbital, and the opioid-like pain reliever tramadol[15]. Note, tramadol became a schedule IV controlled substance in 2014[16].

Prescribing opioids in this patient population

If nonopioid treatments are not able to adequately manage the pain, treatment with opioids should include a clear, written treatment agreement[3]. Because they are concerned about relapse, patients in recovery are often cautious about taking controlled substances; therefore, discuss that relapse does not occur solely as a result of taking opioid medications as prescribed for pain. In addition, cravings for illicit opioids may be lessened by opioid therapy[17].

Other points to consider:

- It is especially important with a history of substance abuse that opioids be taken on a set schedule, because an as-needed administration can lead to dose escalation.
- Prescribing a drug with a lower street value is also a consideration in patients who may be around people and places associated with their addiction[18].
- Prescriptions can be kept and administered by a trustworthy friend or relative to reduce the risk of abuse[15].

CAUTION TIPS

Use caution when prescribing gabapentin. Gabapentin, a non-controlled substance used in the treatment of neuropathic pain, is sometimes abused, especially by patients with opioid addiction. It works synergistically with opioids and so they may be prescribed together. Caution should be used when they are both prescribed and when patients request them.

When Abuse is Suspected

If you suspect a patient is abusing their medication, alcohol, or an illicit drug, first find out *why* the patient has reverted to substance abuse. If a reason is identified, it can be addressed to help avoid further relapse. For more serious substance abuse problems where the patient cannot be trusted with controlled substances (diversion, forged prescriptions, etc.), the patient will need to be tapered off opioids and other forms of nonopioid pain treatment may be considered[13].

KEY POINTS

- Use non-opioid therapies as first line treatment for pain in patients in substance abuse treatment or recovery.
- Consider that it is possible to carefully use opioids in this patient population if necessary.
- Develop a tightened treatment structure and monitoring plan for patients who are in substance abuse treatment or recovery.
- Create a written treatment agreement with the patient that clearly describes these additional measures
- If relapse does occur, identify and address the underlying cause.
- If the patient needs to be taken off opioids, it needs to be done with a taper, and other forms of treatment should be offered.

ELICIT ADDITIONAL SUPPORT FOR THE PATIENT

Family members and other providers should review the agreement and be aware of their roles in support of the patient[10]. Participation in a support group or counseling should be required of patients in recovery or with a recent history of addiction while undergoing opioid treatment for pain. Involving the patient's family and friends who can alert you to concerns about the patient can help you identify and address relapse, as well as improve the patient's treatment adherence[10].

FYI

Between 1998-2008, the percentage of all substance abuse treatment admissions (for persons ≥ age 12 yrs) increased from 2.2 to 9.8%. This increase was evident across gender and all age and racial/ethnic groups[19].

PATIENTS ON MAINTENANCE THERAPY

Patients Maintained on Methadone

When treating pain in this population, patients should continue their methadone maintenance dose, but another medication will need to be added for analgesia. If opioids are required to manage the pain, they should be given around the clock. A multimodal approach, for example adding acetaminophen and an NSAID plus an adjuvant analgesic such as a tricyclic antidepressant, can help spare the amount of opioid needed[20]. See the Related Resource *Methadone Treatment for Pain States* for information on methadone dosing for pain.

Patients Maintained on Buprenorphine

Recommendations for treating acute pain in this population include:

Buprenorphine for opioid addiction is normally administered once a day, which usually cannot provide the around-the-clock analgesia or immediate onset of action required in some pain patients. However, a seven-day buprenorphine patch for treating pain was recently approved by the FDA[21]. Additionally:

- Nonopioids should be the first course of treatment (while continuing maintenance therapy)
- If opioids are needed, they should be spared if possible using a multi-analgesia approach, such as acetaminophen, NSAID, and an adjuvant such as a tricyclic antidepressant[20].
- Anticipated acute pain (such as planned surgery) should be managed by discontinuing the buprenorphine 24 to 36 hours before analgesia for acute pain and titrating a short-acting opioid to effect. Note that a higher dose opioid agonist may be needed, because it will be competing with buprenorphine at the mu receptor. When opioids are no longer required for pain management, the patient should first experience mild to moderate opioid withdrawal and then be reinduced onto buprenorphine. You may want to consult a more experienced buprenorphine provider or pain or addiction expert[20.]
- Patients who are hospitalized with acute pain (for instance, for emergency surgery) can be switched from buprenorphine to methadone during their hospital stay. Addition of other opioids on top of the methadone would be needed because the methadone would be treating the opioid dependence and you would then need to treat the pain typically with a short acting opioid. When the pain is gone, the patient can be tapered off of methadone and re-induced onto buprenorphine[20].

An alternative recommendation for treating chronic pain in buprenorphine-maintained patients:

Methadone maintenance treatment has been recommended as an alternative treatment for individuals with chronic pain and opioid addiction. If the main reason for treating the patient with methadone is for pain management, the patient may be treated in a primary care setting, but if there are problems with abuse, treatment may need to be coordinated with an Opioid Treatment Program[3].

PATIENTS WITH ACTIVE SUBSTANCE MISUSE

APS/AAPM Guideline

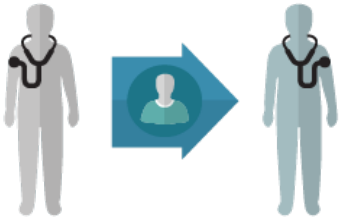
Illicit drugs. Patients actively using illicit drugs are not good candidates for long-term opioid therapy, unless in a highly controlled setting being directly observed, such as a treatment program[3].

Prescription drug misuse/addiction. Patients for whom there is a high suspicion of active substance misuse should receive a similar approach. For example, aberrant use of opioids, after ruling out medication adherence problems, misunderstanding instructions, self-medication of non-pain symptoms, self-medication of pain, and self-escalation of dose to manage pain, suggest current substance misuse or diversion.

Role of the Pain Management Provider

The difference between a patient on chronic opioid therapy and someone who is addicted is that the addicted patient is out of control with their medications (Heit, 2009). In most cases, pain will not resolve while active substance misuse is present; both pain and addiction must be addressed[17].

Treating the Patient vs. Referral:



If a patient is believed to have a substance use disorder, first decide if the treatment of the substance use disorder is within your realm of expertise; if not, referral to an addiction specialist or a treatment program or pain/addiction specialist may be necessary. Other possible reasons for referring include that the patient's level of risk is too high to be appropriately managed in your treatment setting, or the patient has a comorbid psychiatric condition that requires special attention. Discuss the rationale for referral with the patient so they will not feel abandoned[22]. Before referring, consider having a psychiatrist who understands addiction confirm the presence of a substance use disorder[23]. Provide information and referrals to supportive care, such as recovery groups or counseling, to improve treatment effectiveness[24].

COORDINATING CARE AFTER REFERRAL

The role of the pain management clinician does not end with a referral. Continuing to act as an advocate and work with the patient and the addiction specialist improves pain treatment outcomes and can reduce opioid misuse[23,24]. Additionally, addiction specialists who may not want their patients with substance use disorders to be treated with opioids for pain may be willing to allow this if a pain specialist is responsible for the pain treatment and helps monitor the patient[23]. Primary care providers can coordinate care as the patient's medical home, a source for referrals who communicates with specialists and provides ongoing management[22].

Become familiar with the details of the addiction treatment program and making a note of progress and participation in the program at each visit[23].

FYI

Predictors of failure to resolve drug-related aberrant behavior in one study of pain patients with addiction who were on COT were having a history of cocaine use and a higher number of pain diagnoses. Predictor of successful resolving of aberrant behaviors included being married[25].

LAWFUL PRESCRIBING

According to federal law, controlled substances can be prescribed to individuals with an active substance use disorder, as long as the medication is prescribed for a *legitimate medical purpose*[26]. For example:

- Prescribing opioids to a patient with substance abuse who also has legitimate pain is a lawful act
- Prescribing to a patient with substance abuse solely to help him or her through withdrawal in the absence of a legitimate medical condition is illegal.

State regulations vary by state and tend to be more restrictive. The Government Regulations Key Info Guide contains a more detailed discussion of the pertinent DEA laws (21 CFR 1306.04, and 21 CFR 1306.07) as well as information on where to find individual state prescribing regulations.

The conditions and decisions leading up to the prescription of a controlled substance need to be documented in the patient's chart and the prescription must be within the "usual course" of professional practice. For example, if a provider has never met the patient but prescribes a controlled substance via phone, this would not be considered occurring in the usual course of practice.

TREATING PATIENTS WITH SUBSTANCE MISUSE

Current or Prior Substance Misuse

If you decide you can provide the best available treatment for both the patient's substance misuse and pain problems or treat pain in coordination with an addiction specialist, the following measures can help improve outcomes and identify drug misuse:

- *Treatment agreements.* Treatment agreements are a good idea for anyone on long term opioids or other narcotics. (Note that some states require an "Opioid management plan" which may overlap with this document.) A more structured treatment plan that includes increased patient monitoring can also help with these patients[24]. Consider including measures such as the following:

  - Making participation in counseling or supportive programs, such as a twelve-step program, a requirement for continued treatment[10]
  - 24-hour notice pill counts can be conducted to help monitor misuse
  - More frequent urine drug tests, as often as once a week or at each visit for high-risk patients[7,10]. Add temperature strips, pH check, creatinine, and confirmatory testing, to routine urine drug testing as needed to verify the sample is not tampered with and to detect specific opioids. See our Key Info guides on urine drug testing for details.
  - Outline reasons a patient should no longer receive opioid therapy, such as pain and quality of life that are not improving on opioids, pain resolution, addictive behavior that cannot be controlled, and diversion of medications; these are all possible reasons for tapering patients from opioids[7].
- *Adjustments in prescriptions.*
  - The medication itself can be prescribed in small quantities
  - The medication can be dispensed to a trustworthy friend or relative
  - Consider whether a higher dose is needed due to pre-existing tolerance

    - Check prescription drug monitoring programs before prescribing and at least every 3 months. For the high-risk patients consider checking at each prescription if possible[2]. (Note that a few states may not have activated their programs.)
    - Utilize your pharmacy as a resource especially if your state has not activated their prescription drug monitoring program; they can be an invaluable resource.
- *Adjustments in medications.*
    - Nonopioid therapies, such as NSAIDs, tricyclic antidepressants, or antipsychotics should be used as the first line of treatment to manage pain, or can be used with opioids to reduce the required dosage[24]. *Consider increased cardiovascular/cerebrovascular and gastrointestinal risk vs. benefits when prescribing NSAIDs[27].
    - When opioids are necessary to manage pain, long-acting, slow onset drugs are recommended to minimize the risk of misuse[3].
    - Longer-acting, slower onset opioids include methadone and levo-dromoran and may reduce reward.
    - Controlled-release opioids such as morphine, oxycodone, and fentanyl can help maintain stable blood levels to reduce craving[3].
- *Methadone and buprenorphine.* Methadone Maintenance Treatment (MMT) and buprenorphine can be used in addition to opioid therapy in chronic pain patients to help reduce substance misuse. This requires coordination between the pain management provider and an MMT Clinic[7]. Additionally, buprenorphine has been an effective analgesic in chronic pain patients with opioid use disorders[7], and was recently approved for pain treatment.

KEY POINT

- Utilize measures to improve outcomes and identify drug misuse: treatment agreements, adjustments in prescription and medications, and methadone and buprenorphine.

OTHER SUBSTANCES

The approach to a patient who is abusing a substance other than opioids will differ somewhat from one who is abusing opioids. Abusing cocaine, for example, is associated with a higher risk for opioid use problems than other substances[25].

Addiction is a medical problem and should be treated as such[28]. Restricting boundaries are an appropriate response to a single illicit urine drug test while at the same time, making expectations clear that this cannot continue. Consider continued chronic opioid therapy with continually improved compliance.

PRACTICE TIP

Strive for a trusting relationship where openness and acceptance of the patient's pain complaints can result in more honest self-reports.

KEY POINT

- Alter approaches for patients abusing drugs other than opioids; restrict boundaries while clarifying expectations, and accept or reject chronic opioid therapy.

SUMMARY

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

Provide patient-centered care

- Use a sensitive, non-judgmental approach when discussing substance abuse/misuse/addiction.
- Create a written treatment agreement, between patient and provider, when prescribing to high-risk patients.
- Elicit additional support for patients in substance abuse recovery or treatment by involving friends or family members to facilitate patient outcomes.

Work in interdisciplinary teams

- Opt from a spectrum of choices incorporating pain/addiction specialists, for high risk patients.
- After referral, primary care providers can coordinate care with the patient's medical home; the home in turn communicates with specialists, provides daily management, and gives feedback on future referrals.

Employ evidence-based practice

- Patients who use illicit drugs or abuse prescription drugs are weak candidates for chronic opioid therapy.
- Use non-opioid therapies as first line treatment for pain in patients in substance abuse treatment or recovery. Non-opioids should be first line treatment for patients being maintained on methadone or buprenorphine who develop pain.
- Closely monitor patients on chronic opioid therapy who are at high risk for substance abuse with unannounced urine drug tests and pill counts.

Apply quality improvement

- Very high risk patients should be monitored weekly; high-dose patients should be monitored several times weekly.
- If treating a high risk patient, as for all patients being treated with controlled substances for chronic pain, use "universal precautions" with patients at high risk for substance use problems.
- Modify chronic opioid therapy and tighten treatment structure for patients at different stages of recovery
    1. Past history of substance abuse
    2. In treatment/recovery
    3. Active substance abuse
- Changes to make in monitoring for high risk patients include the following:
    1. Periodically, confirm adherence to the opioid plan of care
    2. Decrease intervals between prescriptions/limited prescription quantities
    3. Require participation in counseling or in a support group
    4. Frequently, assess for addiction, abuse, and chemical coping
- In response to aberrant drug-related behaviors:
    1. document aberrant behavior/lack of adherence
    2. Tighten controls and limits on prescribing

3. consider restructuring therapy, specialist referral, or discontinuing long term opioid therapy.

UTILIZE INFORMATICS

- Use the Resources section of this module to review federal, DEA, and state laws for prescribing a controlled substance.
- Understand the documentation requirements and "usual course" standard for prescribing.
- 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.

RESOURCES AVAILABLE THROUGH THIS MODULE:

- Acute Pain Management for Patients Receiving Maintenance Methadone or Buprenorphine Therapy
  This journal article by Alford DP, Compton P, and Samet JH, explores the relationship between addiction, opioid agonist therapies (buprenorphine or methadone), and treating acute pain.
- ASPMN Position Statement: Pain Management in Patients with Addictive Disease
  This position paper discusses considerations when treating patients with chronic pain who also have an addictive disease. Includes recommendations for patients with active addictive disease, patients in recovery, and those on methadone maintenance treatment.
- BupPractice
  BupPractice is a comprehensive website with information and assistance for physicians managing opioid-dependent patients. It has several components, including How-To Guides, a set of ten step-by-step practice guides that provide information and resources on topics related to opioid addiction and setting up and managing office-based buprenorphine treatment, a Resource Center with over 200 searchable, annotated resources, and a Training Center which features links and information for buprenorphine waiver training programs, training resources for staff, clinical case studies related to buprenorphine, and other substance abuse CME programs.
- Challenges in Using Opioids to Treat Pain in Persons With Substance Use Disorders
  Comprehensive review article that explores the relationship between pain and substance abuse and offers suggestions for evaluation and treatment. Authors: Savage SR, Kirsh KL, Passik SD
- Methadone Treatment for Pain States
  This article provides guidance on prescribing methadone for treatment of pain. It discusses the pharmacology, indications, dosing, interactions, and clinical recommendations. (2005)
- Principles of Pain Treatment in Addictive Disorders
  This presentation contains guidelines and recommendations on treating pain in patients with addiction. It includes information on the goals of treatment, the interaction between pain and addiction, drug choice and dosing, and legal issues.
- TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders
  From Treatment Improvement Protocol (TIP) Series from SAMHSA, published in 2012. Title implies this is related to chronic opioid therapy for patients in recovery from substance use

disorders, which it is, but it also is relevant to use of chronic opioid therapy for all patients and preventing substance use disorders.

- Treatment Locators for Referral
  This table provides a list of various pain and addiction treatment locators, to help you find a provider or treatment center in your area for referral. For each treatment locator, a website link and brief summary is provided, and information is included such as what treatment centers/counselors/specialists can be found.
- Universal Precautions in Pain Medicine: A Rational Approach to the Treatment of Chronic Pain
  Describes the Universal Precautions in Pain Medicine, which experts in pain medicine recommend be used with all pain patients. Authors: Gourlay DL, Heit HA, Almahrezi A. 2005.

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