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## **Opioid therapy: managing risks of abuse, addiction, and diversion**

**Chapter:** Opioid therapy: managing risks of abuse, addiction, and diversion

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### **Introduction to opioid therapy**

Over the past decade, an emerging societal health issue has been the troubling increase in prescription drug abuse in the United States (National Center on Addiction and Substance Abuse of Columbia University, 2005). Given the complex and chronic medical problems that are seen in the palliative care setting, there is an increasing need for awareness of this issue, in addition to the potential for diversion of medications to others for illicit use. Traditionally, patients with substance use problems have been considered a homogenous group, but there exists a wide array of patients ranging from those with frank dependency to others with self-escalation of their medication doses without their prescribers' knowledge. Regardless of where patients may lie on the spectrum of substance-related problems, awareness of the existence of such issues is an important component to establishing an appropriate treatment plan.

However, simple awareness is only the first step in management, as these patients create a

quandary for well-intentioned providers, who must balance the potential for abuse of prescribed opioids with the need to provide appropriate analgesia for patients in the palliative care setting. Nevertheless, these patients can be treated safely and effectively while addressing both of these issues.

### Prevalence

Substance use in the United States is not uncommon with approximately half of the population between the ages of 15 and 24 having previously used illicit substances, while another 6–15% has met criteria for a substance use disorder (Regier et al., 1990; Colliver and Kopstein, 1991; Groerer and Brodsky, 1992; Warner et al., 1995; Kessler et al., 2005a, 2005b). Reports in the European Union from 2013 cite up to 38% of the population having a 'disorder of the brain', which includes substance use disorders. This number does include issues of alcohol and tobacco dependence as well, accounting for some of the increased prevalence rates (Effertz and Mann, 2012). Perhaps even more alarming is the increasing misuse of prescription drugs, which increased approximately 94% between 1992 and 2003 (National Center on Addiction and Substance Abuse of Columbia University, 2005). The combination of this high prevalence of use and its association with conditions such as HIV/AIDS, hepatic cirrhosis, and certain cancers (Wells et al., 1989; Blot, 1992; Thun et al., 1997; Smith-Warner et al., 1998; Room et al., 2005) means that issues surrounding substance misuse will arise in the palliative care setting, and will require increasing attention. Clinicians must be aware of the difficulties that may arise with the use of potentially abusable medications with patients who have an active or past problem with substance misuse and the potential difficulties this may cause in providing the patient with optimal care for management of their illness.

The problem of increasing prescription drug misuse is more than a complication of treatment, as it is contributing to a health care crisis where, in the United States, for the year of 2002 alone, it was implicated in approximately 30% of drug-related emergency-room deaths and at least 23% of emergency-room visits (National Center on Addiction and Substance Abuse of Columbia University, 2005). More concerning is that approximately one-third of abusers were new users with a growth of 225% in new opioid abusers between the years of 1992 and 2003. Additionally, during the same time period, there was a 150% increase in the abuse of tranquilizers, a 127% increase in the abuse of sedatives, and a 171% increase in the abuse of stimulants (National Center on Addiction and Substance Abuse of Columbia University, 2005). Given this rapid growth in the general population, new questions have to be raised about the prevalence of problematic use among those seen in the palliative care setting.

Fortunately, it appears that the prevalence of use amongst patients with cancer in tertiary care centres appears to be less than the frequency seen in society and general medical populations (Derogatis et al., 1983; Regier et al., 1984; Burton et al., 1991; Colliver and Kopstein, 1991; Groerer and Brodsky, 1992). For example, less than 1% of psychiatric consultations were requested for substance abuse concerns at Memorial Sloan Kettering Cancer Center (MSKCC) in a 6-month period in 2005 with only 3% of those patients eventually receiving a substance abuse diagnosis (Yu, 2005). A 1983 study by the Psychiatric Collaborative Oncology Group, found substance use conditions in less than 5% of 215 patients with cancer in the ambulatory care setting of several tertiary care hospitals based on structured clinical interviews (Derogatis et al., 1983). When compared to other settings, including emergency departments, general

medical care providers, and society, this prevalence is fairly low (Derogatis et al., 1983; Regier et al., 1984; Burton et al., 1991; Colliver and Kopstein, 1991; Groerer and Brodsky, 1992).

However, this data must be considered carefully, due to the potential of bias, as prevalence has been found to be higher in other settings (Bruera et al., 1995). Potential contributors to lower than expected prevalence, include potential under-reporting and underrepresentation of groups, who may have a higher likelihood of substance misuse, due to potential barriers and access to care. Ultimately, more studies are needed to sort out the true prevalence, but until then, there should remain some index of suspicion for substance use issues so that they can be adequately addressed.

### **Abuse, dependence, and the terminology of substance misuse**

The terminology used in describing the phenomena associated with substance misuse is often problematic, given the widespread misuse amongst members of both the medical community and lay public. Nevertheless, it is imperative that this nomenclature become more standardized and be utilized appropriately in order to facilitate communication between providers and with patients. The American Psychiatric Association (2000) has outlined their criteria for substance abuse and dependence, in the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition, text revision) (DSM-IV-TR), but these can be problematic when applied in the context of medical illness. One major difficulty is inconsistent use or relevant terminology, which interferes with communication between care providers. What will follow is a discussion of the relative terminology.

#### **Tolerance**

Tolerance is defined as a need for increasing doses of a medication to facilitate an effect (Martin and Jasinski, 1969; Dole, 1972). This phenomenon has been observed in a variety of opioid effects including its analgesic effects, as demonstrated in animal models (Ling et al., 1989), as well as respiratory depression and cognitive impairment (Bruera et al., 1989). Although it is often considered negative, there is limited data to support that it creates problems in the medical setting (Foley, 1991; Portenoy, 1994a). In fact, it appears that most patients can be maintained on stable doses of their medications with tolerance being primarily a side effect of the medication. It appears the increasing needs for analgesia when using opioids is more related to progression of the underlying illness (Twycross, 1974; Kanner and Foley, 1981; Chapman and Hill, 1989; Zenz et al., 1992; Aronoff, 2000; McCarberg and Barkin, 2001; Meuser et al., 2001). Moreover, clinical practice does not reliably support the notion that tolerance is a harbinger of substance dependence.

#### **Dependence**

The notion of dependence has to be considered in the context of physical dependence and the much broader substance dependence. Substance dependence, as described in the DSM, is a syndrome that requires maladaptive substance use with drug-seeking behaviour and physical indicators of use including withdrawal and tolerance (American Psychiatric Association, 2000). This is to be considered differently from physical dependence which indicates the presence of withdrawal alone with cessation of use or administration of an antagonist (Martin and Jasinski, 1969; Dole, 1972; Redmond and Krystal, 1984). Although there

is some overlap, with previous speculations that physical dependence drives some of the drug-seeking behaviour associated with substance dependence (Wikler, 1980), these are completely separate entities. Physical dependence is a physiological phenomenon which may not occur in patients taking opioids for pain relief. This is confirmed by animal studies, which have demonstrated that drug-taking behaviour can occur without physical dependence (Dai et al., 1989), and in the clinical treatment of non-malignant pain where patients who have physical dependence are able to discontinue without developing problematic substance use behaviours (Halpern and Robinson, 1985). Clinically, this is an important concept to understand in order to avoid the stigmatization of patients and inappropriate management. This stigmatization is particularly typified in the use of terms such as addiction, which has a pejorative meaning to the general public. This ill-defined term may include both components of problem drug use behaviours as well as physical dependence, and when misused may place patients in danger of having their pain undertreated by well-intentioned clinicians. In general, the label of 'addict' should rarely be used, especially when describing a patient who only has the potential for developing a withdrawal syndrome with substance discontinuation and has no maladaptive behaviours associated with their exposure to the addictive substance.

### **Substance abuse and dependence**

Substance abuse and dependence are the terms designated in the DSM-IV-TR for problematic substance use (American Psychiatric Association, 2000), and should be utilized when discussing these issues. A key component of these designations is the idea of maladaptive behaviours associated with use that occur outside typical societal/cultural norms. However, it is important to recognize that defining normative behaviour is problematic, as evidenced by a survey of pain clinicians which demonstrated significant individual differences when defining the behaviours that were most problematic when ranking aberrant drug-taking behaviours (Passik et al., 2002). Furthermore, normative behaviours will also vary based on the circumstances under which they occur, such as in the chronic pain and medical conditions seen in palliative care.

As a result, problem drug-related behaviours are poorly defined in medically ill populations, which limit appropriate assessment. Furthermore, what defines problem behaviour may differ between provider and the patient, which could impair formation of an appropriate treatment alliance. This was demonstrated in a 2000 pilot study at MSKCC, where inpatients with cancer condoned behaviours typically considered as misuse, when it was done in the context of symptom management, while women, who were inpatients with complications of HIV frequently engaged in behaviours that would commonly be labelled as misuse (Passik et al., 2000). Further complicating the use of these terms in medically ill patients is the lack of clarity with regards to which symptoms should be attributed to the substance use and which should be attributed to the underlying illness, such as the declining physical status of the patient being due to the underlying medical illness and/or their substance dependence. For example, a patient may become less engaged with those around him/her, which may be more related to the progression of their illness than deterioration in social functioning related to their ongoing substance use. Given these and other issues, it can be seen that the use of these terms in medically ill populations are limited.

### **Aberrant drug-related behaviour**

A concise definition of substance dependence was previously proposed by Rinaldi et al., who

described it as a 'compulsive use of a substance resulting in physical, psychological, or social harm to the user and continued use despite that harm' (Rinaldi et al., 1988). However, it could be argued that this definition is not sufficient to help in clinical decision-making. An attempt to develop a model that was more clinically useful has lent itself to the concept of 'aberrant drug-related behaviour'. The importance of this concept is that it moves away from defining and classifying the significance of behaviours that can be associated with misuse, and making it more clinically useful by defining it as an indication to assess patients for problematic substance use. Thus, in practice, a patient who presents with aberrant drug-related behaviours should be viewed as having a symptom of a potentially larger problem for which a differential should be constructed in order to fully address and provide an opportunity to manage a variety of issues that may be negatively impacting the patient's treatment including an underlying psychiatric illness or poor adaptive coping with the stressors of having a chronic medical illness.

At the core of this concept is the idea that aberrant substance use can represent more than a dependency syndrome. For example, a patient may ask aggressively for escalating drug dosage, which may be related to an intense desire to have adequate analgesia as opposed to representing true substance abuse or dependence (also known as pseudoaddiction). This, and other signs of distress, may appear to be aberrant drug-related behaviour and, if misdiagnosed, could produce a missed opportunity to help relieve patient suffering.

In using this model, the degree of aberrancy should be noted. Examples include:

◆ Mildly aberrant:

- requests for specific pain medication
- aggressive complaints about the need for medication
- using drugs prescribed for a friend or family member
- frequent prescription losses
- hoarding drugs

◆ More highly aberrant:

- forging prescriptions
- obtaining drugs from non-medical source
- sale of prescription drugs
- crushing sustained-release tablets for snorting or injecting (Passik et al., 2002).

Less aberrant behaviours are more likely to represent patient distress whereas more aberrant behaviour is more consistent with problem substance use. However, it should be remembered that no specific behaviour should be viewed as pathognomonic for problem drug use and further exploration of any such behaviours should be undertaken if they are present. Examples include:

- ◆ a patient who is forging prescriptions in the context of borderline personality disorder due to their fears of abandonment instead of drug misuse
- ◆ a patient who self-medicates their underlying psychiatric illness, such as depression or

anxiety

- ◆ a patient who misuses their medication due to confusion about their regimen in the context of cognitive deficits such as delirium or an underlying dementia.

In each of these examples, targets for treatment can be easily identified and would not preclude further prescribing of needed pain medications to the specific patient.

### **Empirical studies using the aberrant drug taking concept**

The use of this model appears to have some support based on a few small studies (Dunbar and Katz, 1996; Compton et al., 1998; Passik et al., 2000) and appears to be a clinically useful tool, although larger empirical studies are needed. Dunbar and Katz (1996) examined 20 patients, with varying substance histories, who were being followed on chronic opioid therapy for 1 year. Ultimately, when compared to patients who abused their regimen, they found patients who did not abuse their opioid medications (11 of the 20 patients) were more likely to have abused alcohol alone or had a remote history of polysubstance use, were in community treatment programmes, and had strong psychosocial support. The patients who abused their regimen typically acquired opioids from more than one provider, increased their dose without permission, and made multiple phone calls or unscheduled visits to the clinic.

In another study, Compton et al. (1998) studied a group of patients who were referred to a multidisciplinary pain programme due to aberrant drug-taking behaviours. They examined these patients for a psychiatric diagnosis of substance dependence and found that those who met the criteria were more likely to have experienced a loss of control, increased their dose without permission, and received pain medications from multiple sources, compared to those without a psychiatric diagnosis.

Passik et al. (2000) examined patients with both cancer and AIDS for self-reported measures of attitudes and behaviours with regard to aberrant drug use. They found patients were not opposed either to themselves or others engaging in aberrant drug-taking behaviours if pain and other symptom management were not optimal. In addition, they found that the worry about developing substance dependence was greater than the actual risk.

These studies provide some insight into identifying potential behaviours that may be most concerning with regard to development of substance dependence syndromes with potentially abusable drugs. This is important to consider because of the potential to ascribe aberrant behaviours to substance dependence based on anecdotal evidence instead of following a more evidence-based approach. As a result, patients may be labelled inappropriately with dependence, which may jeopardize their ongoing management. Furthermore, it may lead to a missed opportunity to address the underlying needs or issues that resulted in the observed behaviour. For example, Passik et al. (2000) found that patients who had used anxiety medications that were intended for a friend appeared to have been doing so in an effort to manage undertreated anxiety instead of representing a true dependence syndrome.

### **Risk of substance abuse and dependence in the medically ill**

Due to the growing prescription drug abuse problem in the United States, awareness has



increased, which appears to have inappropriately raised the concern of both clinicians and patients with regard to the potential for developing opioid dependency when being treated for cancer pain. Contrary to this, is the increasing concern in the palliative care community that patients are being undertreated. This is based on available data that indicates the development of a significant substance abuse issue in patients being treated for cancer pain with opioids, with no previous substance abuse history, is a rare occurrence (Health and Public Policy Committee, 1983; Ventafridda et al., 1985, 1990; Walker et al., 1988; Jorgensen et al., 1990; Moulin and Foley 1990; Schug et al., 1990, 1992; World Health Organization, 1990; Ad Hoc Committee on Cancer Pain, 1992; American Pain Society, 1992; Agency for Health Care Policy and Research, 1994; Zech et al., 1995).

Considering this issue raises questions regarding the potential risks and benefits for chronic opioid treatment in patients with non-malignant pain (Zenz et al., 1992; Portenoy, 1994b), which has traditionally been considered negative, especially when considering that a large group of patients who have drug dependence issues began abusing substances after receiving prescribed opioids (Kolb, 1925; Pescor, 1939; Rayport, 1954). In one survey, Caucasian participants with substance dependence had a previous history of medical opioid prescriptions at a rate of approximately 27% compared to only 1.2% of their African American counterparts (Rayport, 1954). This may represent a differential effect that has yet to be identified or may reflect ongoing disparities in the adequate treatment of pain in African American patients.

However, these estimates are flawed, as they do not represent a sample of medically ill patients requiring opioid therapy with no known drug abuse history. One study, which included almost 12 000 inpatients that received opioids while hospitalized, only demonstrated four cases of substance abuse or dependence issues following discharge (Porter and Jick, 1980). In a series including more than 10 000 burn patients without a history of drug abuse, no cases were identified of patients who subsequently developed new substance use disorders. Another study of patients with chronic headaches demonstrated similarly low numbers of patients who developed substance misuse concerns (Medina and Diamond, 1977). Although this does not directly support the safety of long-term opioid therapy in chronic pain patients, it seems promising with regard to their safety potential.

The other component in the ultimate development of substance use issues is potential heritability or a predisposition for developing such a disorder. Evidence now exists that supports the idea of inheritance of predispositions for substance use (Grove et al., 1990), so patients with a genetic loading for these disorders along with exposure to opioids would be expected to have a higher rate of developing a substance use disorder. However, the data currently does not support the concept that patients are likely to develop these issues when treated with drugs that have abuse potential for appropriate medical indications if they have no personal history of substance use or psychopathology, no family history of substance abuse/dependence, and/or no membership in a subculture that fosters abuse (Grove et al., 1990; Zenz et al., 1992; Gardner-Nix, 1996; Aronoff, 2000; McCarberg and Barkin 2001; Meuser et al., 2001; Potter et al., 2004).

### **Risk in patients with current or remote drug abuse histories**

The available information about the risk of exacerbating remote or active substance

abuse/dependence issues in medically ill patients who require prescriptions for substances of abuse is inadequate. There are small reports which seem to support safety in such prescribing in patients, especially when the substance use issues are remote (Macaluso et al., 1988; Gonzales and Coyle, 1992; Dunbar and Katz, 1996). This is further supported by a study of patients, who had AIDS-related pain, who were able to be treated effectively with morphine (Kaplan et al., 2000). Ultimately, this issue needs further investigation and caution should be exercised in these patients with close follow-up and attention to aberrant behaviours.

### **Clinical management**

The presence of aberrant drug use amongst patients with advanced illness represents a major impediment to appropriate care, regardless of the context in which it occurs. In order to maximize patient outcomes and to prescribe needed medications both safely and fairly, the clinician should work to develop appropriate controls and monitoring within their clinical practice.

### **Multidisciplinary approach**

Multidisciplinary teams in the palliative care setting can be an important tool in optimizing treatment for patients with substance use disorders. A structured approach can minimize impediments to treatment for both the patient and the prescriber, who can develop a variety of emotions while treating these patients that may inadvertently affect the quality of pain-related care that is being offered. Teams would ideally include a psychologist, who is trained in addictions, along with adequate nursing and social work support to address the complex needs that patients often have.

### **Assessment**

Once a member of the treatment team becomes concerned about the potential for aberrant substance use, then the other team members should be notified in order to begin a multidisciplinary intervention (Lundberg and Passik, 1997). Due to safety concerns that may arise, a physician should be involved early in the process in order to rule out life-threatening issues such as respiratory depression due to intoxication and/or life-threatening withdrawal symptoms. Once immediate safety has been assured, then an organized assessment should be conducted where information is gathered concerning the nature and extent of the problematic substance use in a non-judgemental and empathetic manner.

One technique to accomplish this is by conducting a graduated interview that proceeds from open-ended and broad questioning to more specific details about substance use, which will allow for a positive rapport to develop and potentially minimize the patients denial of his/her use. In this same manner, information should be gathered about co-occurring psychiatric disorders including anxiety, mood, and personality disorders, which are often co-morbid (Regier et al., 1990; Penick et al., 1994; Grant et al., 2004). Once this information has been gathered a more comprehensive treatment plan can be developed that will allow for the patient's need to be most effectively met.

### **Pre-screening patients**

Much of recent research has been done on developing screening tools that allow for



appropriate risk stratification of patients who will require a treatment plan that includes chronic opioid prescribing. An important component of risk stratification is to be non-judgemental and to be mindful that aberrant substance use occurs on a spectrum that differs between recreational users and those requiring chronic pain treatment with opioids (Kirsh and Passik, 2008) (see Fig. 9.5.1). No assessment tool can diagnose substance misuse disorders alone, and some clinical acumen will need to be applied in order to identify the issues that may be leading to non-adherence.

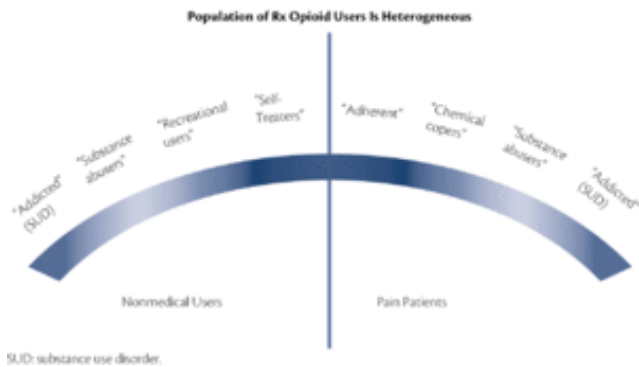


Fig. 9.5.1

The spectrum of adherence for pain patients versus the spectrum of illicit use by nonmedical users.

From Kirsh KL and Passik SD, The interface between pain and drug abuse the evolution of strategies to optimize pain management while minimizing drug abuse, *Experimental and Clinical Psychopharmacology*, Volume 16, Issue 5, pp. 400–404, Copyright © 2008 American Psychological Association. Reprinted with permission.

Assessments tools are available for the purpose of identifying patients who may have problem substance use. A tool, called the Screener and Opioid Assessment for Patients with Pain (SOAPP) is a 24-item self-administered screen, which was validated in patients with chronic non-malignant pain (Butler et al., 2004). A shorter, five-item self-report tool, called the Opioid Risk Tool (ORT) was demonstrated in 2005 to be effective in identifying patients who would later develop aberrant substance use (Webster and Webster, 2005), although it is susceptible to deception. A study by Moore et al. demonstrated that a semi-structured clinical interview had the highest sensitivity alone (0.77), but this was increased to 0.90 when combined with the SOAPP (Moore et al., 2009). However, this study was done on patients primarily with chronic pain and its effectiveness in medically ill patients is unclear.

### The four As for ongoing monitoring

Analgesia, Activities of daily living, Adverse side effects, and Aberrant drug-taking behaviours have been labelled the 'Four A's' of necessary monitoring for patients with chronic pain on opioids (Passik and Weinreb, 2000). Utilizing these four domains is useful in treatment planning and clinical decision-making. A checklist tool (Passik et al., 2004) has been developed:

- ◆ **Analgesia:** document and monitor patient's pain, using scales such as a 0–10 pain rating scale. Although listed as the first 'A,' analgesia is not necessarily to be considered the most

important outcome of pain management. An alternate view is how much relief it takes for a patient to feel that their life is meaningfully changed so they can work toward the attainment of their own goals.

◆ *Activities of daily living*: monitor patient's typical level of daily activities and psychosocial functioning to observe increases over time. The second 'A' concerning activities of daily living refers to quality of life issues and functionality. It is necessary that patients understand that they must comply with all of their recommended treatment options so that they are better able to return to work, avocation, and social activities.

◆ *Adverse effects*: strive for the highest analgesia with the most benign side effect profile. Patients must also be made aware of the adverse side effects inherent in the treatment of their pain condition with opioids and other medications. Side effects must be aggressively managed so that sedation and other side effects do not overshadow the potential benefits of drug therapy. The most common side effects of opioid analgesics include constipation, sedation, nausea, vomiting, and dry mouth.

◆ *Aberrant behaviours*: be aware of aberrant behaviours suggestive of drug use, such as multiple 'lost' prescriptions or unauthorized dosing escalations. Patients must be educated through agreements, or other means, about the parameters of acceptable drug taking. Even an overall good outcome in every other domain might not constitute satisfactory treatment if the patient is non-adherent with the contract in concerning ways. Dispensing pain medicine in a highly structured fashion may become necessary for some patients who are in violation or constantly on the fringes of inappropriate drug taking behaviours.

### Development of a treatment plan—general considerations

A treatment plan with clear goals will need to be individualized for each patient in an effort to curtail and manage aberrant drug-related behaviours. The ultimate overall goal is for 'harm reduction' as poor coping and dealing with chronic illness may interfere with adequate management (Passik et al., 1998). The key elements of this approach are:

1. Approach the patient with empathetic listening and attempt to understand their distress.
2. Utilize non-opioid interventions as part of management, but not as a substitute.
3. Utilize the patient's history of aberrant use in determining dosing and choice of medication that will offer the best outcome.
4. Frequent reassessment of the adequacy of pain and symptom control.

### Urine toxicology screening

Non-adherence to treatment planning and aberrant substance use pose a variety of issues that could negatively impact prognosis. Due to this, it is imperative that appropriate monitoring be undertaken. The most useful and often easily obtained form of monitoring is the urine toxicology screening. However, one chart review in 2000 at a tertiary care centre showed that these screens were not often used by providers (Passik et al., 2000) and when used often demonstrated problems that decreased their effectiveness.

One of the difficulties in the use of urine toxicology screenings is a non-standardized approach, where clinicians make their decisions on who to test based on their own assessment of who they feel is at risk. However, this is not a reliable practice and could potentially miss problem behaviours, which would have been readily identified with testing. This unreliability

was tested by Bronstein et al. (2011) who asked clinicians to identify patients who they felt were most at risk for aberrant drug use. They found that clinicians missed a significant group of patients who had no identifiable risk factors, but were able to identify patients more reliably when assessment tools were used.

Given that clinicians are not reliable in assessing those patients who do not have recognizable risk factors or problem behaviours, it is of great importance that drug screens be performed in a standardized and reliable way and performed on a randomized basis to minimize the ability of patients to predict testing in an effort to deceive screening.

The patient with advanced disease

The management of patients with advanced medical illness is a difficult task at baseline, but aberrant substance use can negatively impact efforts to offer appropriate palliative care. Ultimately the palliative care team and other treatment providers must work together to minimize risk, which may be as simple as a reduction in use, which could have a positive effect on the patient (Passik and Theobald, 2000). Box 9.5.1, lists some interventions that could be utilized in managing risk. These include screening tools for monitoring a variety of conditions, prescription monitoring programmes, which provides information on adherence to providers (Passik, 2009), and the previously mentioned urine drug screens. It is also important to remind patients to control their prescriptions carefully as studies have shown that prescription opioids are commonly diverted to family and friends for non-medical use (Passik, 2009). A final safety guard is opioid formulations and delivery strategies that minimize the potential for misuse, such as physical barriers.

### Box 9.5.1 Screening for substance abuse and treatment recommendations

#### Assessment guidelines

- ◆ Use a graduated interview approach beginning with broad questions about substances such as nicotine or caffeine and becoming more specific.
- ◆ Assess for comorbid psychiatric disorders, such as anxiety, mood, and personality disorders.
- ◆ Consider diagnostic instruments, such as the Screener and Opioid Assessment for Patients with Pain (Butler et al., 2004).

#### Treatment recommendations

##### General

- ◆ Listen and accept the patient's report of distress.
- ◆ Use behavioural and non-opioid interventions for pain when possible.
- ◆ Consider drugs with slower onset and longer duration (e.g., transdermal fentanyl and modified-release opioids). Note that higher doses may be needed for adequate pain control in patients with a history of abuse or dependence.

- ◆ Frequently assess adequacy of symptom and pain control.

### Outpatients

- ◆ Limit amount of drug dispensed per prescription.
- ◆ Make refills contingent on clinic attendance.
- ◆ Consider urine toxicology screenings to assess usage.
- ◆ Involve family members and friends in the treatment plan.

### Inpatients

- ◆ Consider placing the patient in a private room near the nurses' station.
- ◆ Consider daily urine collection.

Source: data from Butler SF, et al. Validation of a screener and opioid assessment measure for patients with chronic pain, *PAIN*, Volume 112, Issue 1, pp.65–75, Copyright © 2004 International Association for the Study of Pain. Published by Elsevier B.V. All rights reserved.

### Outpatient management

Outpatient management can be done safely and effectively. An important step to ensure a structure for appropriate management is to have the patient agree to a written treatment contract that is a mutually agreed upon document that establishes the boundaries of treatment. This may include such issues as frequency of urine drug screens, expectations in obtaining refills, expectations for outpatient substance abuse treatment, contingency plans for problem drug use, and expectations for the involvement of family and friends.

### Inpatient management

In the inpatient setting, issues of misuse still remain a problem as patients may develop a variety of issues in regards to their substance use. This includes withdrawal syndromes, which may only become apparent after the patient no longer has access to the amount of medication they take at home. Aberrant substance use within the inpatient hospitalization can also be problematic and in extreme cases, visitors may need to be restricted and/or searched upon their arrival along with the patient's belonging. However, remain cognizant of the negative feelings that this may elicit from patients who may view this as an invasion of privacy. The goal of maintaining safety should be communicated to the patient and, when possible, the patient should be included in the process in order to facilitate a more positive working relationship. Clinicians should also be aware of intravenous access in patients with a known history of intravenous drug use and of the potential for patients to leave the floor to purchase illicit substances. The patient should be monitored carefully for both safety and adequate pain management with an individual plan that is designed to meet his/her needs.

## Conclusion

Aberrant drug-related behaviour is a complex phenomenon that can occur in the chronic

medically ill patient and needs to be approached in a manner that allows for recognition of the biological, chemical, psychological, and social aspects of it. The spectrum of behaviours that fall within this category is broad and, unfortunately, not well defined in terms of outcome, management, and potential difficulties. Nevertheless, we must continue to approach patients with these issues in an empathic manner, with the ultimate goal of safely managing their pain, while addressing other issues that are leading to their distress and perpetuating their aberrant drug use.

### Online materials

Additional online materials and complete references for this chapter are available online at <<http://www.oxfordmedicine.com>>.

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### **Additional material and online references**

Appendix

#### **Box 9.5.2 Risk management package for patients undergoing opioid therapy**

- ◆ Screening and risk stratification
- ◆ Use of prescription monitoring programme data

- ◆ Compliance monitoring
- ◆ Urine drug testing
- ◆ Pill or patch counts
- ◆ Education about drug storage and sharing
- ◆ Psychotherapy and highly structured approaches
- ◆ Abuse-deterrent or abuse-resistant strategies in opioid formulation.

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