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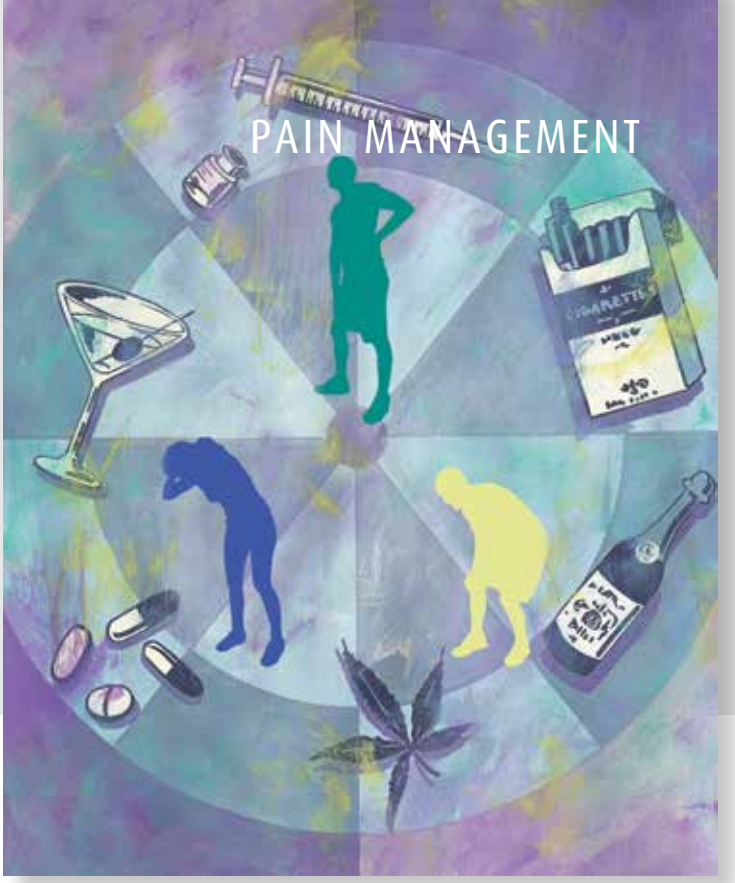

Persistent noncancer pain in patients with addiction

Reflecting on the challenges

SHALINI ARUNOGIRI MB BS(Hons), MPsychiatry, FRANZCP, CertAddictionPsych
MATTHEW FREI MB BS, FAChAM
DAN LUBMAN BSc(Hons), MB ChB, PhD, FRANZCP, FAChAM

Patients who present with persisting noncancer pain on a background of a past or current substance use disorder are a common management challenge. Often they are perceived as quintessential 'heartsink patients'. However, by maintaining an empathic perspective clinicians can help to create a productive therapeutic relationship.

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Dr Arunogiri is a Consultant Addiction Psychiatrist at Turning Point (Eastern Health), Melbourne. She also works in private practice and is a doctoral candidate at Monash University, Melbourne.
Dr Frei is Clinical Director of Turning Point (Eastern Health) and Adjunct Senior Lecturer at Monash University, Melbourne.
Professor Lubman is Director of Turning Point (Eastern Health) and Professor of Addiction Studies and Services at Monash University, Melbourne, Vic.

Over the past two decades, opioid prescribing for persisting noncancer pain has been increasing, both in Australia and internationally. This increase in prescribing may be justified by the evidence that oral opioids can be effective in controlling pain severity and improving function in the short term;[1] however, the associated increase in risks of morbidity and mortality in some patients is also well documented.[2] Long-term use of opioids for pain is associated with a wide range of harms, including addiction (characterised by physical and psychological dependence and aberrant behaviours related to opioids and pain), toxicity and overdose, drug–drug and drug–disease interactions, and problems of drug diversion and illicit use (e.g. the sale and purchase of opioid analgesics in black markets). Opioid misuse has become a major public health issue in Australia and in other countries – in the USA, for example, overdose deaths involving opioid analgesics now exceed deaths from heroin and cocaine combined.[3]

RISKS OF LONG-TERM OPIOID TREATMENT

Any patient who is prescribed long-term opioid treatment can develop behavioural problems related to the medication, often termed 'aberrant behaviours', which are 'red flags' for the development of addiction (Box 1). Estimates vary, but researchers have found that up to 30% of individuals who are prescribed long-term opioid treatment have features of medication misuse.[4] For individuals who have a history (current or previous) of a substance use disorder, the risk of developing such problems is higher. When prescribing opioid treatment, clinical vigilance is needed to identify individuals who may be at increased risk of developing problems associated with the medication and to determine when risk mitigation strategies are indicated.

PRESCRIBING OPIOID ANALGESICS

Initiating treatment

A standardised 'universal precautions' approach to opioid prescribing was first suggested in 2005 by Gourlay and colleagues.[5] These authors advocated a structured assessment for all individuals, conducted in a nonjudgemental and evidence-based manner, prior to commencing treatment with an opioid medication (Box 2).

Current international consensus guidelines also discuss common principles of best practice that can be applied to mitigate the risks associated with prescribing opioids for noncancer pain.[3] These guidelines recognise that special provisions are needed to manage persisting noncancer pain in patients at highest risk for addiction, such as those with a current or previous substance use disorder (including for alcohol and nicotine) or a family history of substance use disorder. Although a history of a substance use disorder does not entirely preclude patients from accessing opioid analgesia for persisting pain, it should alert a prescriber to the need for careful consideration of the risks and benefits of such treatment.

There are several useful screening instruments, available online, that can be used to identify individuals who are at risk of misusing opioids. These include the Opioid Risk Tool (http://docs.health.vic.gov.au/docs/doc/Assessing-patients-when-considering-treatment-with-opioids)[6] and the Screener and Opioid Assessment for Pain (http://bit.ly/1F6B2km).[2] These instruments will usually place patients with a history of a substance use disorder in a high-risk category, but they may provide additional information and assist in the evaluation of other risk factors, such as comorbid mental health problems.

The assessment of a patient with pain on a background of substance use is complex. GPs may find it helpful to seek the opinion of an addiction medicine specialist or pain medicine specialist when formulating a management plan.

Continuing treatment

GPs often 'inherit' patients with active substance use problems who have already been commenced on opioid treatment. Rather than feeling compelled to continue high-risk management of pain with potent opioid analgesics, a GP can view this situation as an opportunity to discuss conditions for continuing treatment with the patient and to lay down ground rules. It may be that continuing opioid treatment should only be considered within the context of a gradual reduction or tapering plan or in the form of substitution treatment with opioid maintenance pharmacotherapy such as methadone or buprenorphine/naloxone. GPs may find it helpful to obtain the advice of an addiction medicine specialist to support them in this process.

OTHER ASPECTS OF MANAGEMENT

An individual with a history of problematic substance use may have a limited repertoire of coping skills, a comorbid psychiatric illness or an acquired brain injury, which adds a degree of complexity when trying to deal with pain. It is important to explore psychological approaches to managing pain and comorbid issues as part of a management plan. Although a thorough discussion of such approaches is beyond the scope of this article, some considerations could include a focus on enhancing coping strategies (such as promoting exercise, distraction techniques, mindfulness and supportive social connections) and addressing negative schema. This can be supported by a focus on function (improving functional outcomes) rather than focusing solely on the experience of pain. A range of psychological therapies, including cognitive behavioural therapy and mindfulness or meditation-based approaches, can also help an individual develop skills to cope with pain. A multidisciplinary team model, with referral to psychologists, physiotherapists or other professionals can further support a comprehensive management plan.

Self-help and patient information websites, such as the American Psychological Association's Pain Management Website (http://www.apa.org/helpcenter/pain-management.aspx) or the British National Health Service (NHS) Pain Toolkit (http://www.paintoolkit.org) can also be helpful, as can attendance at support groups for individuals with chronic pain.

1. EXAMPLES OF ABERRANT BEHAVIOURS IN PATIENTS PRESCRIBED LONG-TERM OPIOID TREATMENT

- Frequent unsanctioned dose escalations
- Obtaining of scripts from multiple doctors
- Obtaining of medication from nonmedical sources
- Stealing or borrowing of drugs from others
- Concurrent abuse of alcohol or illicit drugs
- Recurrent prescription loss
- Injecting of oral formulations
- Prescription forgery
- Selling of prescription drugs

THE DOCTOR–PATIENT RELATIONSHIP

Patients who have co-occurring chronic pain and a substance use disorder can elicit a strong negative response in treatment providers. Often, they are quintessential 'heartsink patients'.[7] It is important to recognise a negative response when it occurs and to understand the reasons behind it. A patient's problems may seem intractable and repeated visits without any improvement in symptoms or function can result in frustration and therapeutic nihilism. It can also take a great deal of time, effort and patience to comprehensively manage the range of problems associated with this group of patients. Clinicians may think that they are working harder to solve the problem than a patient and that the patient is not actively participating in their recovery.

2. STRATEGIES TO MINIMISE HARMS ASSOCIATED WITH LONG-TERM OPIOID TREATMENT

Comprehensive assessment and examination

- Comprehensive pain and substance use history, including collateral history and communication with other treatment providers, to answer the following key questions:
  - what is the underlying pain diagnosis?
  - what are the current substance use problems?
  - what comorbidities require assessment and treatment (e.g. acquired brain injury, mental illness)?
  - what are the risks related to long-term opioid treatment for this patient (e.g. tolerance, addiction, diversion or selling of medication, toxicity, drug–drug interactions)?

Investigations and collateral history

- Appropriate investigations for pain (imaging, nerve conduction studies, etc)
- Urine drug screen to detect substance use
- History from previous prescribers and treatment providers, regulation authorities

Use of tools and instruments

- Pain – such as the Pain Assessment and Documentation Tool (PADT)
- Substance use – such as the Alcohol Use Disorders Identification Test (AUDIT) and Drug Use Disorders Identification Test (DUDIT)
- Mental health – such as the Kessler Psychological Distress Scale (K10)
- Opioid risk assessment tools, if opioid treatment is being considered – the Opioid Risk Tool (http://docs.health.vic.gov.au/docs/doc/Assessing-patients-when-considering-treatment-with-opioids)[6] and the Screener and Opioid Assessment for Pain (http://bit.ly/1F6B2km)[2]

Adapted from: Gourlay DL, Heit HA. Universal precautions in pain medicine: the treatment of chronic pain with or without the disease of addiction. Medscape Neurol Neurosurg 2005; 7: 1-4 (reference 5).

Treatment plan and contract

- Identification of goals of treatment – specific goals with emphasis on functional outcomes
- Education regarding side effects and risks of treatment(s)
- Nonpharmacological pain management strategies
- Opioid analgesics – consider opinion from addiction medicine specialist, and following strategies to mitigate risks:
  - only one prescriber
  - only one dispensing point
  - no selling or giving of medication to others
  - no provision for early scripts
  - no replacement of lost scripts
  - consideration of limited dispensing (incorporate reasonable limits on the number of pills prescribed so the amounts prescribed match the number of treatment days/time between appointments)
  - consideration of random urine drug testing and random pill counts
  - consideration of use of a consent form for Prescription Shopping Information Service for higher risk patients (http://www.medicareaustralia.gov.au/provider/pbs/prescription-shopping)

Treatment monitoring and review (4A's)

- Analgesia
- Activity
- Adverse events
- Aberrant behaviours – one or more 'red flags' (see Box 1) should trigger discussion with the patient and with regulatory authorities, consideration of referral to an addiction medicine specialist or pain medicine specialist, and consideration of methadone or buprenorphine/naloxone for opioid dependence
  Note: Patients taking opioid doses ≥ 120 mg morphine equivalent should be referred for specialist review

Documentation

- Thorough documentation at all steps in the process

Situations can arise where there is doubt about the veracity of the patient's history. The clinician may believe the patient is not reporting 'genuine pain' or is deliberately 'drug seeking'. Negative experiences can also colour future interactions with patients with similar problems. Many of these factors affect the dynamics of the doctor–patient relationship, and it can be helpful to consider strategies to address this.

Keys to fostering a therapeutic doctor–patient relationship are the same for this patient group as for those with any other clinical presentation. They include:

- open and honest communication
- consistent messages and plans
- consistent and frequent appointments for review and monitoring
- clear boundaries and conditions of treatment.

It is especially important to maintain a consistent and systematic approach in managing this patient group because of the inherent level of complexity of care and the medicolegal and regulatory structures associated with opioid prescribing. Key approaches include:

- thorough and timely documentation
- familiarity and compliance with legislative and regulatory requirements
- communication and liaison with other treatment providers
- seeking of expert opinion and advice where necessary
- peer review and support.

By maintaining a clinical perspective of empathy with patients affected by pain and addiction, clinicians can help to create a productive therapeutic relationship. Reframing the 'heartsink patient' as an individual who produces a 'heartsink reaction' or engenders a 'heartsink relationship' can shift the focus of the 'heartsink' itself; these responses have been described as the responsibility of the treatment provider 'rather than being an inherent characteristic of any particular patient'.[8] The reactions that a patient provokes in the clinician may be similar to reactions that he or she elicits in others around them. Reflective practice, taking into account these reactions and feelings and pursuing support through discussion with peers and colleagues and/or exploring options for shared care with a psychologist or addiction medicine specialist, will result in effective practice and enable the clinician to remain a source of hope.

CONCLUSION

Prescribing opioid medications for individuals with co-occurring pain and a history of substance use disorder can be challenging for many doctors. However, incorporation of strategies to minimise physiological, psychological and medicolegal risks can make the treatment journey as painless as possible for both the doctor and patient. MT

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