Target Audience

- The overarching goal of PCSS is to train a diverse range of healthcare professionals in the safe and effective prescribing of opioid medications for the treatment of pain, as well as the treatment of substance use disorders, particularly opioid use disorders, with medication-assisted treatments.
Outline

- SCOPE OF PROBLEM
- CHRONIC PAIN
- ASSESSMENT OF PAIN
- MONITORING PAIN

Educational Objectives

- At the conclusion of this activity participants should be able to:
  - Describe the difference between chronic pain and acute pain
  - Discuss pain in the patient with substance use disorders
  - Describe one evidence-based intervention for pain in the patient with a substance use disorder

The International Association for the Study of Pain (IASP) defines pain to be "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage".

Pain can be separated into two broad categories:

- acute pain, which is pain that lasts for less than six months
- chronic pain, which lasts six months or longer.
Does Pain management differ in a the patient
with a substance use disorder???

Scope of the Problem

Epidemiology
- Americans (4.6% of the world’s population) consume approximately 80% of the
  world’s opioid supply.
- Americans consume 99% of the world’s supply of hydrocodone (Vicodin).

Prescription Drug Overdose State Rates


Chronic Pain

Chronic pain affects approximately 100-116 million American adults – more than the total affected by
heart disease, cancer and diabetes combined (IOM 2011)
• Estimates of addiction among chronic pain patients vary widely from about 3 to 48%. This variability is
  the result of – Differences in treatment duration
  – Insufficient research on long-term outcomes
  – Disparate study populations and measures used to assess abuse or addiction.
Evidence for Use of Opioids for Chronic Non-cancer Pain (CNCP)

Safe and effective therapy requires clinical skills and knowledge in both the principles of opioid prescribing and the assessment and management of risk associated with opioid abuse, addiction, and diversion

- Consensus recommendations
  - Careful patient evaluation
  - Structure opioid therapy to accommodate identified risks
  - Appropriate initiation and titration of opioids
  - Regular and comprehensive monitoring
  - Anticipate and manage opioid-related adverse effects
  - Use therapies targeting psychosocial factors
  - Complex patients: multidisciplinary management team


More Americans are Using and Dying from Prescription Painkillers Than From Heroin

Prescription Opioids Fatalities

- Associated with more overdose deaths than heroin and cocaine combined
- Fatal Overdoses grew nationally for the 11th consecutive year to 38,329 driven by prescription drug use
- Overdose is the second leading cause of death for 45-55 y.o.

(Source: 1. SAMHSA DSDUH, 2007 2. CDCP, 2010.)
Prescription Opioid Abuse

Slightly greater than 5% of people in the US 12 years and older used prescription pain medications for non-medical purposes, more than the combined number who were abusing or dependent on illicit drugs.

• Nearly 80% of heroin users began with prescription opioids

(Source: 1. 2011 and 2012 NSDUHs, SAMHSA; 2. Eric Holder, former attorney general; The Nation’s Health, 2014)


When prescribing any controlled substance, there is always concern about misuse, abuse, and diversion

• Prior to starting treatment with controlled substances in a chronic pain management setting, there should be a well-documented addictions history including problems with prescription medications, illicit substances, alcohol, and tobacco.
• Use of an evidence-based screening tool is recommended.
• A history of substance abuse and/or other addictions is not an absolute contraindication to treatment with controlled substances, but it does require a different approach.
• If the addiction is active, detoxification may be required.

Criteria for opioid dependence

According to DSM-5…

“A problematic pattern of substance use leading to clinically significant impairment or distress, as manifested by at least 2 of the following, occurring within a 12 month period…”

DSM-V Substance (Opioid) Use Disorder Criteria

• (Impaired Control)
  1.Use in larger amounts or longer than intended
  2.Desire or unsuccessful effort to cut down
  3.Great deal of time using or recovering
  4.Craving or strong urge to use
• (Social Impairment)
  5.Role obligation failure
  6.Continued use despite social/interpersonal problems
  7.Sacrificing activities to use or because of use
(Risky Use)
8. Use in situations where it is hazardous
9. Continued use despite knowledge of having physical or psychological
   problem caused or exacerbated by use
   • (Neuroadaptive/Physiologic)
10. Tolerance
11. Withdrawal

Severity and Specifiers
Severity ranges from mild to severe based on the number of
   symptoms
   – Mild: two to three symptoms
   – Moderate: four to five
   – Severe: six or more
   • Course Specifiers – “In early remission”
     – “In sustained remission”
     – “On maintenance therapy”
     – “In a controlled environment”

Assessing Pain and Substance Use Disorders
Use of assessment tools reduces clinician bias
   • No single tool for all populations: memory problems, cognitive
     impairments, eyesight, literacy, culture, gender, ethnicity
   • Patients with SUD may
     – Over report pain experience for fear of being under treated
     – Some under-report if they fear being prescribed medications that will result
       in relapse
     – Some exaggerate pain and disability to get medications for reasons other
       than their own pain management
   • Encourage honesty
Why Screen?

- Opioid dependence is on the rise
  - Misuse of prescription pain-killers (Oxycontin, Percocet, Vicodin) and heroin has increased in 10 years
  - 2000: 810,000-1 million Americans addicted to opioid
  - 2003: 1.5 million Americans
  - 2006: 2.4 million
  - Prevalence of heroin use: comparable to 1960’s

- Dramatic increase in # of young heroin users: decreased price, increased purity
  - (7% 2-3 decades ago to approximately 36.1% in 2006, 46% in 2011 and 58% purity in 2014-DEA)

Source: 1. ONDCP; 2. NSDUH

Why Screen?

Opioid abuse and misuse often goes undetected

- Non-medical use of prescription opioids was associated with the largest number of new users than any other illicit drug category
- Nearly 1 in 10 high school seniors reported nonmedical use of Vicodin; 1 in 20 reported abuse of OxyContin

- Patients are likely to be more receptive, open, and ready to change than you expect
  - Most patients don’t object to being screened by clinicians and are open to hearing advice afterward
  - Most primary care patients who screen positive for drug or alcohol use disorders show some motivational readiness to change; and
  - Those who have the most severe symptoms are often the most ready to change

- You are in a prime position to make a difference – Brief interventions can promote significant, lasting reductions in at-risk patients who are not yet dependent
  - Some patients who are dependent will accept referral to addiction treatment programs
  - Even for patients who don’t accept referrals immediately, repeated visits with health providers can lead to significant improvement

Screening Methods

Brief Screens

- CAGE (4-item screen for alcoholism) vs CAGE-AID (Adapted to include Drugs)
- NIAAA-1 (National Institute on Alcohol Abuse and Alcoholism) 1-item screen for alcohol use
- NIDA-1 (National Institute on Drug Abuse) 1-item screen for drug use
- CRAFFT (for adolescents and young adults)

- Brief Assessments
  - AUDIT (Alcohol Use Disorders Identification Test) for alcohol use
  - DAST-10 (Drug Abuse Screening Test) for drug use

(Source: Partners in Integrated Care.)
CAGE

• Have you ever felt you needed to Cut Down on your drinking?
• Have people Annoyed you by criticizing your drinking?
• Have you ever felt Guilty about drinking?
• Have you ever felt you needed a drink first thing in the morning (Eye-Opener) to steady your nerves or to get rid of a hangover?

CAGE-AID (Adapted to Include Drugs)

1. In the last three months, have you felt you should cut down or stop drinking or using drugs?
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?
3. In the last three months, have you felt guilty or bad about how much you drink or use drugs?
4. In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?

• Each affirmative response earns one point
• One point indicates a possible problem
• Two points indicate a probable problem


Single Screening Question for Alcohol: NIAAA-1

• “How many times in the past year have you had X or more drinks in a day”
  X = females 4 or more; males 5 or more
  — Never
  — Less than once a month
  — Monthly
  — Weekly
  — Daily or almost daily
  • Positive score >0
  • Any response other than never warrants assessment for problem drinking:
    give AUDIT questionnaire

Source: Smith et al. SASQ in Primary Care, 2009.
Alcohol Use Disorder Identification Test (AUDIT)

1. How often do you have a drink containing alcohol?
2. How many standard drinks containing alcohol do you have on a typical day when drinking?
3. How often do you have 5 or more drinks on one occasion?
4. How often during the last year have you found that you were not able to stop drinking once you had started?
5. How often during the last year have you failed to do what was normally expected of you because of drinking?
6. How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session?
7. How often during the last year have you had a feeling of guilt or remorse after drinking?
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
9. Have you or someone else been injured as a result of your drinking?
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

Single Screening Question for Drugs: NIDA-1

• "How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?"
  – Never
  – Less than once a month
  – Monthly
  – Weekly
  – Daily or almost daily

• Positive score >0
• Any response other than never warrants assessment for problem use
• Give DAST-10 questionnaire

Source: Smith et. al., SDSQ in Primary Care 2011.

Screening Adolescents/Young Adults

PART A

• During the past 12 MONTHS did you
  1. Drink any alcohol (more than a few sips)
  2. Smoke any marijuana or hashish
  3. Use anything else* to get high

* Anything else includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff"
PART B

• Have you ever ridden in a car driven by someone, including yourself, who had been using?
• Do you ever use to relax, feel better about yourself, or fit in?
• Do you ever use when you are alone?
• Do your friends or family ever tell you that you use too much?
• Have you ever ridden in a car driven by someone, including yourself, who had been using?
• Do you ever forget things you did while you were using?
• Have you ever been in trouble because you were using?

Two or more yes answers suggest a serious problem. Comprehensive assessment is available through the Adolescent Substance Abuse Program (ASAP)

Drug Abuse Screening Test (DAST-10)

1. Have you used drugs other than those required for medical reasons?
2. Do you abuse more than one drug at a time?
3. Are you always able to stop using drugs when you want to?
4. Have you had “blackouts” or “flashbacks” as a result of drug use?
5. Do you ever feel bad or guilty about your drug use?
6. Does your spouse (or parent) ever complain about your involvement with drugs?
7. Have you neglected your family because of your use of drugs?
8. Have you engaged in illegal activities in order to obtain drugs?
9. Have you experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding etc...)?

Principles of Safe Opioid Prescribing

• The physician is obligated to exert his/her best efforts to relieve pain (beneficence)
• The physician is obligated to treat pain in a manner that minimizes risks to the patient and collateral, including prescription opioid abuse and diversion (non-maleficence)
• Opioids are the most effective analgesics yet have significant risks including abuse and diversion
• Make a diagnosis (nature of the pain)
• Develop realistic goals (managing not eliminating pain)
• Ensure the patient is benefiting from the medication
• Use non-opioid medications and non medication management (physical therapy, exercise, acupuncture, massage, transcutaneous electric nerve stimulation, etc.)
• PDMP before prescribing opioids
• Opioid trial
• Use controlled substance agreements/contracts
• Provide only a limited supply (2-4 weeks’ supply), or less
• Identify concurrent psychiatric and/or other substance use disorders
• Document clearly the elements of the pain management plan
• Use long-acting opioids with caution
Non-Opioid Pain Management Options

Nociceptive Pain
- Mechanical supports
- Body mechanics, postural work
- NSAIDS
- COX-2 inhibitors (celecoxib, rofecoxib)
- Steroids

Neuropathic Pain
- Tricyclic antidepressants
- Anticonvulsants (gabapentin, carbamazepine, oxcarbazepine)
- Alpha-2 adrenergic agonists (clonidine)
- NMDA-type glutamate receptor antagonists (ketamine)
- Topical anesthetics (Lidocaine)

Monitoring

- 6 A’s (pain and functional assessment) – Analgesia
  - Affect
  - Activities of daily life
  - Adjunctive therapies
  - Adverse effects
  - Aberrant behaviors
- Random urine toxicology for illicit substances and non-prescribed medications
- Frequency depends on the level of risk
  - Low risk: every 3-6 months
  - High risk: weekly may be needed

Monitoring Tools

- ABC - Addiction Behavior Checklist – track problematic behavior during the current visit and between visits 1
- COMM - Current Opiate Misuse Measurement (patient self-assessment to track aberrant medication-related behaviors over the course of treatment 2)
- PADT - Pain Assessment and Documentation Tool - chart note to assess and document clinician observations when treating chronic pain patients on opioid therapy 3
Medication Category Choices

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<thead>
<tr>
<th>Category</th>
<th>Short-acting</th>
<th>Long-acting</th>
<th>Partial agonists</th>
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<tbody>
<tr>
<td>(Oxycodone, hydrocodone)</td>
<td>Poor maintenance choice/better rescue med</td>
<td>Longer analgesic half life</td>
<td>Better safety profile</td>
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<td>(Oxycodone HCL, methadone)</td>
<td>Requires frequent self administration</td>
<td>Dosing frequency varies by drug</td>
<td>Analgesic ceiling: may not be as effective for pain</td>
</tr>
<tr>
<td>Partial agonists (Buprenorphine)</td>
<td>Rapid onset attractive</td>
<td>Safety concerns at high doses</td>
<td>Sublingual Buprenorphine not approved in US for pain; off-label use</td>
</tr>
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<td></td>
<td>On-off switch difficult to bring pain under control</td>
<td>May require rescue doses of short-acting</td>
<td>Shows promise; research needed for pain</td>
</tr>
</tbody>
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Risks of Opioid Therapy Outweighs Benefits

Criteria
- Inability to maintain analgesia
- Insoluble side effects
- Unsuccessful opioid conversion
- Persistent noncompliance
- Failure to make progress or deterioration in function

Intervention
- Review agreement upon treatment agreement and need to use opioids
- Clarify discontinuation of opioid treatment is not for patient’s benefit
- Clarify that discontinuation of opioids does not mean abandoning pain treatment

Addiction
- No addiction, taper required
- Unable to cooperate

Referral/Co-management
- Addiction Treatment Methadone or Buprenorphine

• Taper 25% per week as tolerated
• Use comfort meds for discomfort
• Nonpharmacologic strategies (psychosocial, Diet, PT, etc.)

• 1 month taper or maintenance and admission for IUD (injection)
• Refer for outpatient taper
• If patient non-compliant during taper, provide 25% less from preceding week
• If excessive concerns; provide frequent visits, small amounts for taper

Closing Message

• Screen all patients for risk for opioid misuse
• Assess aberrant drug use behavior
• Use your PDMP
• Dose judiciously when using opioids
• Continually evaluate the benefit of potentially risky drugs
• Continually monitor for aberrant behavior and opioid misuse
• Provide treatment for pain and addiction
  – Know the regulations
  – Know when you can treat on your own
  – Consider incentives
  – Know when to refer to specialty programs
• Coordinate, Collaborate, Communicate.
References

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  - www.asam.org
  - www.aaoam.org
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- Institute of Medicine, NIH. Relieving Pain in America, March 2012.
- SAMHSA, DHHS Treatment Improvement Protocol (TIP 54).
  Managing chronic pain in adults with or in recovery from substance use disorders, 2012.

PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.
- PCSS Mentors are a national network of providers with expertise in addictions, pain, evidence-based treatment including medication-assisted treatment.
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

For more information visit: pcssnow.org/mentoring

PCSS Discussion Forum

Have a clinical question?
PCSS is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

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Funding for this initiative was made possible (in part) by grant nos. 5U79TI026556-02 and 3U79TI026556-02S1 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.