

## SECTION 4: CHRONIC PAIN AND SUBSTANCE ABUSE

The presence of chronic pain and substance abuse presents two challenges:

- How to treat pain effectively.
- How to identify and manage addictive behavior.

### *General Principles*

- Appropriate pain management, including opioids, should not be withheld in patients with current or past substance abuse disorders.
  - A fear of triggering or worsening addictive disease should not preclude the use of effective therapy. While some clinicians consider a history of addiction to be a contraindication to opioid therapy, failure to provide effective pain management may ultimately reinforce addictive behavior.
  - Respect all patients' rights to pain management.
  - **No scientific evidence suggests that providing opioid analgesia worsens addictive disease.**
- Addiction is a chronic disease.
  - The medical model best guides the approach to the patient with chronic pain and an addiction history—addiction is a chronic disease with biological, genetic and environmental factors. It is characterized by periods of remission and relapse and responds best to open communication and provider consistency.
- Clinicians should differentiate between patients with current and past addiction problems and manage them according to whether they are:
  - “recovering” – both abstinent from substance use for more than 12 months and involved in an ongoing process of well-being that acknowledges their addiction history.
  - “at risk” – not currently using substances but not in active recovery, as defined above; or in early recovery (1-12 months abstinent).
  - “actively using” – actively using or abstinent less than 1 month.

## PART I: PRINCIPLES OF PRESCRIBING OPIOIDS

### *Section 4: Chronic Pain and Substance Abuse*

- As with all patients, non-drug and non-opioid therapy are first line. However, if pain relief is inadequate, opioids may be indicated.

#### **When opioids are indicated**

- Openly discuss the history of addiction and the patient's current state of recovery.
- Discuss, develop, and consistently enforce written treatment plans and contracts with the patient and caregivers.
  - Provide the patient with a copy.
  - Consider notifying other clinicians and the health plan involved in the patient's care.
- Be consistent in pain assessment, using the same method and evaluator.
- Consider the use of a pain diary.
- Use a single opioid when possible.
- Avoid fast-onset drugs with short half lives (e.g. Vicodin, Percocet), which have been reported to produce more euphoria or "high" than long-acting drugs in some patients.
- Prescribe opioids on a regular schedule rather than PRN.
- Document all aspects of pain management—pain assessments, copies of prescriptions, prescription refill requests, and related communication.
- Don't misinterpret behavior: inadequate pain control can cause anxiety and preoccupation with maintaining medication supply, which appears as "drug seeking." This is known as "pseudoaddiction."
- Prescribe generic opioids. They have less "street-value" than brands.

## *Further Considerations*

### **For the “Recovering” Patient**

- Openly discuss the history of addiction and their current recovery process.
- Recovering clients may resist or fear opiate prescriptions as a relapse trigger. Discuss relapse prevention planning, such as re-engaging with outpatient addiction treatment, 12-step meetings, or a 12-step sponsor.
- Don’t withhold pain medication for fear of relapse or to “keep the patient off drugs.” Assess pain management frequently and stop medication if ineffective or if the clinical problem is resolved.

### **For the “At Risk” Patient**

- Openly discuss any history of addiction and address signs of abuse and relapse. Be direct and concrete (e.g. “When have you used pot, heroin, alcohol”).
- Watch for signs and symptoms of opioid intoxication or withdrawal.

#### **Opioid Intoxication**

Lethargy  
Slurred speech  
Constricted pupils  
Slow respiratory rate

#### **Opioid Withdrawal**

General discomfort, agitation  
Sweats  
Shakes  
Nausea, diarrhea, vomiting  
Rhinorrhea  
Elevated blood pressure

- Consult with an addiction counselor or mental health professional if further help is needed. The patient’s health plan can assist you in this process.
- Prescribe generics—they have less “street-value” than brands.
- Write out the prescription quantity instead of using numerals, (e.g. qty: thirty, not qty: # 30).

## PART I: PRINCIPLES OF PRESCRIBING OPIOIDS

### Section 4: Chronic Pain and Substance Abuse

- Consider asking the health plan to restrict or “lock” opioid and other related prescriptions as necessary to one provider and one pharmacy (see below).
- If necessary, designate a home health nurse or trusted family member to be in charge of opiates, i.e. conducting pill counts, pre-pouring one day at a time, adding a dated label to a fentanyl patch, etc.
- Be suspicious of specific requests for the following:
  - Brand name prescriptions which have a higher street value.
  - **Benzodiazepines**, especially clonazepam (Klonopin). Benzodiazepines are commonly abused in combination with opiates to potentiate the high and moderate the withdrawal effects.
  - **Promethazine (Phenergan)**. A common misconception among clinicians is that promethazine adds analgesic benefit to opioids. There is little evidence to support any effect other than potentiation of the opioid “high” and moderation of withdrawal.
  - **Carisoprodol (Soma)**. The skeletal muscle relaxant carisoprodol is metabolized to meprobamate, a barbiturate associated with the potential for dependence and addiction. Carisoprodol has limited efficacy for short term treatment of musculoskeletal conditions and is generally ineffective for chronic pain. No evidence exists for a clinically significant effect other than sedation.
- If doing urine drug screens, consider consulting an addiction expert for help in interpretation of positive results, which may be complicated, e.g. MDMA (“ecstasy”) will cause a (+) amphetamine result.

#### **How to limit a patient to one pharmacy, one prescriber:**

1. To limit prescriptions to one pharmacy, call the health plan. Limitation can be placed on only opioids or all medications. The health plan will then inform the plan’s pharmacy benefits manager only to authorize payment for the specified prescriptions presented to the designated pharmacy. The patient can also be limited to a single prescriber. Patients may still purchase prescriptions at other pharmacies by claiming they have no coverage and paying cash.
2. If the patient only uses one or two pharmacies and you wish to limit prescribers, call the pharmacists directly and instruct them only to honor prescriptions by the designated prescriber(s).

## *Special Considerations*

### **For “Actively Using” Patients**

- Make addiction evaluation and treatment a requirement for pain treatment.
  - Provide a 7-day supply of opioids to allow time for an intake appointment and paperwork. If more time is needed to complete the addiction assessment, a second 7-day supply may be prescribed.
  - Use a written contract specifying that a copy of the addiction evaluation and any treatment recommendations will be sent to your office before refills will be written.
  - If addiction treatment is recommended, the written medication contract should specify adherence to the addiction treatment plan as a condition for continued pain treatment with the PCP. The medication contract should also specify monthly updates from the addiction treatment program to verify treatment plan adherence.
- If addiction treatment is not indicated, proceed as above for “at risk” patients.
- Once addiction treatment is initiated, there should be regular consultation between the PCP and the Medical Director or Clinical Supervisor of the addiction clinic. (Contact information is provided at the end of this section.)
- If the treatment plan is not followed, discontinue prescribing opioids, as specified in medication contract.
  1. Discuss the non-adherence with the patient and document the discussion or send a written letter explaining your actions and reasons, with a copy saved in patient’s record.
  2. Notify the addiction treatment program if a valid release of information is in place.
  3. Notify the patient’s health plan.

### **Diversion of Opioids**

- If you suspect a patient is diverting prescribed opioids, confront them directly and concretely about your concerns.
  - Explain exactly why you are suspicious, e.g. “This is the second time this month you’ve ‘lost’ your prescription.”

## PART I: PRINCIPLES OF PRESCRIBING OPIOIDS

### Section 4: Chronic Pain and Substance Abuse

- Remind the patient of the relevant portions of the medication contract.
- Consider a urine drug screen for evidence of opiates if you believe pills are being diverted. If negative, confront patient with the evidence that they are not taking meds as prescribed.
- If you have evidence of fraud and/or abuse call the patient's health plan and report your suspicions.

**EXAMPLE:** An 83-year-old woman is admitted to the hospital with pneumonia. She has been receiving monthly prescriptions of oxycodone at her family's request because of complaints of continuing pain from a pelvic fracture last year. They report she has been using the oxycodone regularly up to admission. She appears uncomfortable on admission and a fentanyl patch is ordered for pain. The next day, she is noted to have respiratory depression, which is reversed with naloxone (Narcan). Urine obtained on presentation to the ED is sent for analysis and found to contain no opioids.

#### **For Patients on Methadone Maintenance Therapy (MMT)**

- Patients on MMT receive only enough methadone to block opiate withdrawal and cravings. They will often require additional analgesia for pain, even at relatively high methadone doses.
- MMT clients may have lower pain tolerance and/or decreased sensitivity to opiates, requiring higher doses of analgesics.
- Patients in MMT programs may receive opioids for pain, including increased methadone. In some patients it may be useful to differentiate pain treatment from addiction treatment by using a different opioid than methadone. **In all cases, it is essential to coordinate prescribing with the MMT program.**
- Avoid mixed opioid agonist-antagonists (i.e. Talwin, Stadol, Nubain) which can cause acute withdrawal.
- When prescribing analgesics for MMT patients, coordinate with the MMT program. Contact the Medical Director or Program Director for consultation. (Contact information is provided below.)

- If a MMT patient is admitted to the hospital the attending should immediately contact the MMT Program Director to verify current treatment and dose.

### ***Coordination of Care with Addiction Treatment Programs***

Collaboration between addiction treatment and primary care providers allows both systems to work together in addressing the patient’s needs.

- Addiction medicine providers need to understand the patient’s medical status. They are required by national guidelines (The American Society of Addiction Medicine’s Patient Placement Criteria - ASAM PPC-2) to assess the patient’s biomedical status, as well as psychological, social, and environmental factors, to determine addiction treatment level-of-care decisions.
- Many addiction treatment patients become aware of their medical problems only after they have started their recovery program. Addiction counselors are often the first to know of these conditions and refer them to primary care.
- Coordination of care avoids “splitting,” or playing one provider off another by selectively providing or withholding information from one provider.

### **Contacting addiction treatment programs**

*Methadone Programs:* Contact the program Medical Director—or if not available, the Program Director or Clinical Supervisor.

- NTN Portland One, dba Allied Health Services: Dr. Walt Byrd, 503-226-2203
- Delta Clinics: Dr. Richard Orth, 503-630-4210 or 503-239-5738
- CODA: Dr. Jerry Larson, 503-239-8400
- RAM (Recovery And Methadone) Clinic: Dr. John Cleland, 503-408-9585
- Marion County A&D: Dr. Walt Byrd, 503-588-5358—ask for Kathleen Walker, RN
- Jackson County Human Services: 541-776-7355
- Integrated Health Services: Dr. Wendy Callander, 503-353-9415 or 541-842-3900

## PART I: PRINCIPLES OF PRESCRIBING OPIOIDS

### *Section 4: Chronic Pain and Substance Abuse*

*Non-Methadone Addiction Treatment Programs:* Contact the Program Director or the Clinical Supervisor. Program phone numbers can be found in the *Directory of CareOregon Network Providers* in the “Drug and Alcohol Dependency” section, online at [www.careoregon.org](http://www.careoregon.org) using the provider directory search feature in the *Clinicians* section of the website, or by calling a CareOregon Customer Advocate at 503-416-4100 or 1-800-224-4840 outside the Portland metro area.