Pain, Opioids, & Substance Use Disorders

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Disclosure Statement

• Employee of Depomed, Inc. from February 2016 – February 2018.
• No other disclosures.
Learning Objectives

- Define the following terms: physical dependence, tolerance, addiction, and substance use disorder.
- List tools that assist providers in determining pain levels in patients who are recovering from addiction and explain how the information from these tools can be utilized when selecting an appropriate analgesic regimen.
- Discuss strategies that can be implemented by providers to ensure effective pain management for patients in addiction recovery, including opioid treatment agreements and opioid regimen selection.
- Describe methods to treat opioid use disorder while concurrently treating pain.
# Pain is a Problem!

<table>
<thead>
<tr>
<th>Condition</th>
<th>Incidence</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Pain</td>
<td>100 million Americans</td>
<td>Institute of Medicine of The National Academies</td>
</tr>
<tr>
<td>Diabetes</td>
<td>25.8 million Americans (diagnosed &amp; estimated undiagnosed)</td>
<td>American Diabetes Association</td>
</tr>
<tr>
<td>Coronary Heart Disease (heart attack &amp; chest pain)</td>
<td>16.3 million Americans</td>
<td>American Heart Association</td>
</tr>
<tr>
<td>Stroke</td>
<td>7.0 million Americans</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>11.9 million Americans</td>
<td>American Cancer Society</td>
</tr>
</tbody>
</table>

Chronic Pain

• 22% of primary care visits focus on pain
• Chronic pain patients visit primary care providers up to 5 times more often than patients with other chronic conditions
• Cost to United States (US) healthcare is $261-300 billion/year
• Lost productivity estimated $297-336 billion/year
• Opioids accounted for 20% of overall drug cost
  • $3.57 billion/year between 2000-2007

## US Opioid Consumption - 2011

<table>
<thead>
<tr>
<th>Drug</th>
<th>mg/capita</th>
<th>ME mg/capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fentanyl</td>
<td>1.8314</td>
<td>152.6069</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>8.9984</td>
<td>44.9918</td>
</tr>
<tr>
<td>Methadone</td>
<td>48.8338</td>
<td>195.3353</td>
</tr>
<tr>
<td>Morphine</td>
<td>73.7779</td>
<td>73.7779</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>211.4415</td>
<td>281.2172</td>
</tr>
<tr>
<td>Meperidine</td>
<td>7.4276</td>
<td>1.8569</td>
</tr>
<tr>
<td><strong>Total Morphine Equivalence</strong></td>
<td></td>
<td><strong>749.7859</strong></td>
</tr>
</tbody>
</table>
Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2016

Sources of Prescription Opioids Among Past-Year Non-Medical Users

- Given by a friend or relative for free
- Prescribed by ≥1 physicians
- Stolen from a friend or relative
- Bought from a friend or relative
- Bought from a drug dealer or other stranger
- Other

Percent of Users

Number of Days of Past-Year Non-Medical Use

- Any
- 1-29
- 30-99
- 100-199
- 200-365

Some states have more opioid prescriptions per person than others.

Number of opioid prescriptions per 100 people

- 52-71
- 72-82.1
- 82.2-95
- 96-143

SOURCE: IMS, National Prescription Audit (NPA™), 2012.
How do we reconcile these problems?
Terminology Associated with Opioids

- Addiction
- Pseudo-addiction
- Physical Dependence
- Tolerance
- Pseudo-tolerance
- Substance Use Disorder
Question

• What is opioidophobia?
Answer

• Opiophobia – the irrational fear by clinicians and/or patients related to appropriate opioid use for analgesic purposes. This phenomenon appears to be due in part to misunderstanding such terms as addiction, dependence & tolerance.
Narcotic – a term many clinicians still inappropriately use when they refer to opioid analgesics.

This archaic term was used to describe opium & its derivatives in prior generations.

Today the word narcotic is a legal term that includes a wide range of sedating & potentially abused substances, & is no longer limited to opioid analgesics.
What is this?

• HG is a 39 yr old caucasian female with intermittent back pain.
  ✷ Never diagnosed, never prescribed opioids.
• She is routinely “chewing” controlled release oxycodone that is prescribed for her mother, although her mother is unaware of this.
• HG is always calling the physician & pharmacy to pick up the Rx early for her mother.
Addiction

Compulsive use of a substance resulting in

- physical
- psychological, or
- social harm

to the user

and

Continued use despite of that harm

Addiction is a primary, chronic disease of brain reward, motivation, memory & related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social & spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use & other behaviors.

Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors & interpersonal relationships, & a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse & remission. Without treatment or engagement in recovery activities, addiction is progressive & can result in disability or premature death.

American Society of Addiction Medicine
Public Policy Statement – April 2011
Substance Use Disorder: DSM 5 Criteria

*Mild: 2-3 criteria; Moderate: 4-5 criteria; Severe: > 6 criteria*

1. Taking the substance in larger amounts & for longer than intended
2. Wanting to cut down or quit substance use but not being able to do it
3. Spending a lot of time obtaining the substance
4. Craving or a strong desire to use substance
5. Repeatedly unable to carry out major obligations at work, school, or home due to substance use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by substance use
Substance Use Disorder: DSM 5 Criteria

7. Stopping or reducing important social, occupational, or recreational activities due to substance use

8. Recurrent use of substance in physically hazardous situations

9. Consistent use of substance despite acknowledgment of persistent or recurrent physical or psychological difficulties from use

10. Tolerance defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount
   • (Does not apply for diminished effect when used appropriately under medical supervision)

11. Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal
   • (Does not apply when used appropriately under medical supervision)
What is this?

• DP is a 52 yr old Hispanic female with chronic headaches.
• She has been prescribed hydrocodone/APAP 5/500 mg & has been using 4-6 tablets daily for the past 3 months & is now out of her prescription for the past 24 hours.
• She presents to the clinic with tremors, severe nausea & is sweating profusely. She states she really needs her drugs!!!
Physical Dependence

A physiological phenomenon characterized by:
- abstinence syndrome upon
  - abrupt discontinuation
  - substantial dose reduction
  - administration of an antagonist

Occurs with steroids & many other drugs
- nearly universal with regularly scheduled opioids

**Opioids & Dependence**

- Abstinence syndrome can be induced
  - By administration of an antagonist
  - By marked dose reduction
- Time to onset variable
  - May occur as soon as after a few days of consistent dosing
  - Marked inter-patient variability
- Not clinically significant if abstinence syndrome avoided
- Does not independently cause or indicate addiction
Tolerance

• Is tolerance a good thing, a bad thing or just a thing?
Opioid Tolerance

- Tolerance
  - Diminished drug effect from drug exposure
  - Varied types: associative vs pharmacologic
  - Tolerance to side effects is desirable
  - Tolerance to analgesia is seldom a problem in the clinical setting
    - Tolerance rarely “drives” dose escalation
    - Tolerance does not cause addiction
Types of Opioid Tolerance

Tolerance to Analgesia
may occur in first days to weeks of therapy;
Rare after pain relief achieved with consistent
Dosing without increasing or new pathology.

Tolerance to Respiratory Depression &
Sedation
occurs predictably after 5-7 days of
consistent opioid administration.

Tolerance to Constipation
does not occur; scheduled stimulating
laxatives are indicated with regularly
scheduled opioids.

What is this?

• VB is a 25 yr old African American male with diabetic peripheral neuropathy.
• He has been prescribed methadone 5 mg PO BID + Morphine Sulfate IR 10 mg PO Q4H prn pain. (Rx for 60 tabs monthly)
• VB has called early each month (x4 months) for morphine & states the methadone doesn’t work. Really wants to see if can get more morphine (2-3 tabs/dose effective) or if can switch to oxycodone.
Pseudo-addiction

- Appropriate drug seeking behavior
  - Presents as aberrant drug-related behaviors
  - Driven by poor pain control
  - Patients demand dose increases/refills before scheduled
- Viscous cycle of anger, isolation, & avoidance leading to complete distrust
- Can be relieved by improved analgesia

Pseudo-addiction

How aberrant can behavior be before it is inconsistent with pseudo-addiction?

Can addiction & pseudo-addiction coexist?
RY is a 29 yr old male Vietnamese American with post-herpetic neuralgia.
He has been receiving morphine sulfate immediate release 10 mg every 4 hours prn pain for the past couple weeks & uses an average of 3 doses daily with good pain relief.
He recently has been discharged & states he is now needing 5-6 doses daily for pain relief.
• Progressive disease
• New pathology
• Excessive activity
• Noncompliance

• Medication changes
• Drug interaction
• Drug diversion
• Addiction
Cdc Guideline for Prescribing Opioids for Chronic Pain

Promoting Patient Care and Safety

The US Opioid Overdose Epidemic

The United States is in the midst of an epidemic of prescription opioid overdoses. The amount of opioids prescribed and sold in the US quadrupled since 1999, but the overall amount of pain reported by Americans hasn’t changed. This epidemic is devastating American lives, families, and communities.

40

More than 40 people die every day from overdoses involving prescription opioids.

165K

Since 1999, there have been over 165,000 deaths from overdose related to prescription opioids.

4.3M

4.3 million Americans engaged in non-medical use of prescription opioids in the last month.

Prescription Opioids Have Benefits and Risks

Many Americans suffer from chronic pain. These patients deserve safe and effective pain management. Prescription opioids can help manage some types of pain in the short term. However, we don’t have enough information about the benefits of opioids long term, and we know that there are serious risks of opioid use disorder and overdose—particularly with high dosages and long-term use.

249M

Enough prescriptions were written for every American adult to have a bottle of pills.
Recommendation 2: *(category: A; evidence type: 4)*

- Before starting opioid therapy for chronic pain, clinicians establish treatment goals, including realistic goals for pain & function, & consider how opioid therapy will be discontinued if benefits do not outweigh risks.
- Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain & function that outweighs risks to patient safety.
  - Clinicians may use validated instruments such as the 3-item “Pain average, interference with Enjoyment of life, & interference with General activity” (PEG) Assessment Scale\(^{103}\) to track patient outcomes.
  - Clinically meaningful improvement has been defined as a 30% improvement in scores for both pain & function.
- Because depression, anxiety, & other psychological comorbidities often coexist with & can interfere with resolution of pain, clinicians should use validated instruments to assess for these conditions & ensure that treatment for these conditions is optimized.
CDC Opioid Guidelines
Recommendation Highlights

Determining When to Initiate or Continue Opioids for Chronic Pain

• Recommendation 3: (category: A; evidence type: 3)
  • Before starting & periodically during opioid therapy, clinicians should discuss with patients known risks & realistic benefits of opioid therapy & patient & clinician responsibilities for managing therapy.
Opioid Selection, Dosage, Duration, Follow-up, & Discontinuation

• Recommendation 7: (Recommendation category: A; evidence type: 4)
  • Clinicians should evaluate benefits & harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.
  • Clinicians should evaluate benefits & harms of continued therapy with patients every 3 months or more frequently.
  • If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies & work with patients to taper opioids to lower dosages or to taper & discontinue opioids.
Why taper?

• Lack of efficacy
  • No improvement in function/failed trial
  • Inadequate analgesia
  • Failure to reach treatment goals
• Therapy not needed any longer
  • Pain resolving(ed)
• Surgical setting
• Unacceptable risk
  • Adverse effects
  • Opioid-induced hyperalgesia & glial cell activation
  • Employer prohibits drugs that may affect motor coordination
Case

- RD is a 44 yr old woman who does factory work. She has nonspecific low back pain & has been using nabumetone & tramadol 100mg q6hr for > 2 years. Her dose was reduced to 100mg q8hr (or 6 tabs/day). She reports that since the dose reduction she has not been able to go to work for the past 2 weeks due to pain. She requests that her dose be returned to 100mg q6hr.
Case Continued

• RD has been consistent with refills & per state PMP she has not been receiving controlled substances from any other provider.

• Per clinic policy she was identified for random UDT which was unremarkable except for (+) cocaine, confirmed
Why taper?

- Behavioral concerns
  - Abnormal UDT
  - Noncompliance
    - Over or under utilization
  - Misuse/abuse of medication
    - Including diversion
  - Use for reasons other than pain
    - eg. Anxiety, sleep
Taper or just stop?

Patients considered opioid tolerant are those receiving any of the following for 1 week or longer:

- 60 mg morphine/day
- 25 mcg transdermal fentanyl/hr
- 30 mg oral oxycodone/day
- 8 mg oral hydromorphone/day
- 25 mg oral oxymorphone/day
Opioid Taper Guidelines

- American Pain Society & American Academy of Pain Medicine
  - 2009
- Veterans Affairs – Department of Defense
  - 2010
- Canadian National Opioid Use Guideline Group
  - 2010
- Agency Medical Directors Group
  - 2010
- American Society of Interventional Pain Physicians
  - 2012
APS – AAPM 2009 Guideline

Slow
• 10% weekly reduction

Rapid
• Anecdotal evidence for > 200 mg oral Morphine Equivalents
• 25-50% every few days
• Slow taper once oral Morphine Equivalents reach 60-80 mg daily
VA – DoD 2010 Guideline

Variable
• 20-50% weekly taper
• Slower tapering may be warranted

Rapid
• 20-50% Daily until
  ❖ Morphine Oral 45 mg daily;
    ▪ then by 15 mg every 2-5 days until DC
  ❖ Methadone Oral 30 mg daily;
    ▪ Then reduce by 5 mg daily every 3-5 days until 10 mg daily;
    ▪ Then reduce by 2.5 mg every 3-5 days until DC
Canadian National Opioid Use Group
2010 Guideline

Slow
• 10% total daily dose every 1-2 weeks

Rapid
• 10% total daily dose every day

Caveats
• Once 1/3 of original daily dose is reached, reduce taper rate by at least 50%
• Consider converting hydromorphone & oxycodone patients to morphine to begin taper
  ❖ Use 50% of calculated equianalgesic dose.
Agency Medical Directors Group 2010 & American Society of Interventional Pain Physicians 2012

- Decrease dose by 10% of original dose
- Some patients may be weaned more rapidly over 6-8 weeks
Adjusting tapers

- Patients with anxiety & fear about tapering
  - May not be emotionally ready
- Recurrence or worsening of pain
  - Re-evaluate reasons for taper & minimum effective dose
- Withdrawal symptoms
  - Tends to occur at about 30-45mg/day MEDD
  - Taper is too fast, slow by 50%
  - OR hold current dose & treat symptoms
Assessing Risk & Addressing Harms of Opioid Use

Recommendation 8: (Recommendation category: A; evidence type: 4)

Before starting & periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.

- Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose such as:
  - history of overdose; history SUD; higher opioid dosages; concurrent benzodiazepine use

- Certain risk factors can increase susceptibility to opioid-associated harms.
  - Patients with moderate or severe sleep-disordered breathing; Pregnancy; Patients with impaired hepatic or renal function; Age ≥ 65 years; Presence of depression or mental health conditions
Assessing Risk & Addressing Harms of Opioid Use

Recommendation 8 continued : (Recommendation category: A; evidence type: 4)

• If clinicians consider opioid therapy for patients with drug or alcohol use disorders or for patients with prior nonfatal overdose, they should discuss increased risks for opioid use disorder & overdose with patients, carefully consider whether benefits of opioids outweigh increased risks, & increase frequency of monitoring opioid therapy.

• Clinicians should consider offering naloxone when prescribing opioids to patients at increased risk of overdose, including patients with a history of overdose, patients with a history of substance use disorder, patients taking benzodiazepines with opioids, patients at risk of returning to a high dose to which they are no longer tolerant (eg, patients recently released from prison), & patients taking higher dosages of opioids.

• Practices should provide education on overdose prevention & naloxone use to patients receiving naloxone prescriptions & to members of their households.
• Review history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations (e.g. benzos) that put patient at high risk for overdose.
• Review PDMP data when starting opioid therapy for chronic pain & periodically during therapy for chronic pain, ranging from every prescription to every 3 months.
  • Clinicians should discuss safety concerns, including increased risk for respiratory depression & overdose, with patients found to be receiving opioids from more than 1 prescriber or receiving medications that increase risk when combined with opioids (eg, benzodiazepines).
  • Clinicians should avoid prescribing opioids & benzodiazepines concurrently whenever possible.
  • Clinicians should consider the possibility of a substance use disorder & discuss concerns with their patient.
Assessing Risk & Addressing Harms of Opioid Use
Recommendation 10: (Recommendation category: B; evidence type: 4)

• When prescribing opioids for chronic pain, clinicians should use urine drug testing (UDT) before starting opioid therapy & consider UDT urine at least annually to assess for prescribed medications as well as other controlled prescription drugs & illicit drugs.
  • Assess for prescribed opioids as well as other controlled substances & illicit drugs that increase risk for overdose when combined with opioids, including nonprescribed opioids, benzodiazepines, & heroin.
• Clinicians should be familiar with the drugs included in UDT panels used in their practice & should understand how to interpret results for these drugs.
• Clinicians should not dismiss patients from care based on UDT result. This could have adverse consequences for patient safety, including missed opportunities to facilitate treatment for substance use disorder.
The Federal 5

Table 1. Initial cutoff concentrations used during federally-regulated testing

<table>
<thead>
<tr>
<th>Drug</th>
<th>Cutoff concentration (ng/mL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana metabolites</td>
<td>50</td>
</tr>
<tr>
<td>Cocaine metabolites</td>
<td>300</td>
</tr>
<tr>
<td>Opiate metabolites</td>
<td>2000</td>
</tr>
<tr>
<td>Phencyclidine</td>
<td>25</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>1000</td>
</tr>
</tbody>
</table>

Example of Point of Care UDT
Opiate Screens & UDT?

- Opiates are naturally occurring opioids
  - Codeine & morphine

- Rarely sensitive for semi-synthetic agents (e.g. oxycodone)

- To determine methadone (a synthetic opioid) a specific assay is required
Question

- A patient has a UDT & is prescribed methadone. He is actually taking the methadone but the UDT is not specific for methadone. Is this a false negative? Why?
<table>
<thead>
<tr>
<th></th>
<th>Patient has taken drug</th>
<th>Patient has not taken drug</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positive test result</strong></td>
<td>True positive</td>
<td>False positive</td>
</tr>
<tr>
<td><strong>Negative test result</strong></td>
<td>False negative</td>
<td>True negative</td>
</tr>
</tbody>
</table>

Pitfalls of UDT for Compliance

- Not actually using the medication
- Relationship of timing of last dose of medication to the UDT
- Rapid excreter or metabolizer of the substance
- pH of urine
- UDT not sensitive enough
- Clerical errors caused to a positive UDT to be reported as negative.
CDC Opioid Guidelines
Recommendation Highlights

Assessing Risk & Addressing Harms of Opioid Use
Recommendation 12: (Recommendation category: A; evidence type: 2)

- Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.
  - If clinicians suspect opioid use disorder based on patient concerns or behaviors or on findings in PDMP data or from urine drug testing, they should discuss their concerns with their patient & provide an opportunity for the patient to disclose related concerns or problems.
- Clinicians should assess for opioid use disorder using DSM-5 criteria.
- Physicians prescribing opioids in communities without sufficient treatment capacity for opioid use disorder should strongly consider obtaining a waiver from SAMHSA that allows them to prescribe buprenorphine to treat patients with opioid use disorder.
- Clinicians unable to provide treatment themselves should arrange for patients with opioid use disorder to receive care from a substance use disorder treatment specialist, such as an office-based clinician who prescribes buprenorphine or naltrexone treatment, or from an opioid treatment program certified by SAMHSA to provide supervised medication-assisted treatment for patients with opioid use disorder.
Critical outcomes
• Pain relief
• Function
  ▪ physical
  ▪ psychosocial
• Side effects
• Drug-related behaviors

The “4-A's of Pain"
• Analgesia
• Activities of daily living
• Adverse effects
• Aberrant drug-taking behaviors

Aberrant Drug-taking Behaviors

**Major**
- Selling prescription drugs
- Prescription forgery
- Stealing or borrowing another patient’s drugs
- Injecting oral formulation
- Obtaining prescription drugs from nonmedical sources
- Concurrent abuse of related illicit drugs
- Multiple unsanctioned dose escalations
- Recurrent prescription losses

**Minor**
- Aggressive complaining about need for higher doses
- Drug hoarding during periods of reduced symptoms
- Requesting specific drugs
- Acquisition of similar drugs from other medical sources
- Unsanctioned dose escalation 1–2 times
- Unapproved use of the drug to treat another symptom
- Reporting psychic effects not intended by the clinician

Screening Tools for Opioids & Substance Misuse

- ORT: Opioid Risk Tool
  - Simple 5 Question Tool
- SOAPP: Screener Assessment for Patients with Pain
  - Proprietary
  - Multiple versions (8, 14, & 24 Question Versions)
- CAGE-AID: CAGE Adapted to Include Drugs
  - Simple 4 Question Tool
- COMM: Current Opioid Misuse Measure
  - Proprietary
  - 17 Questions
<table>
<thead>
<tr>
<th>OPIOID RISK TOOL</th>
<th>Mark each box that applies</th>
<th>Male Score</th>
<th>Female Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family History of Substance Abuse</td>
<td>Alcohol [ ] 1 3</td>
<td>Illegal Drugs [ ] 2 3</td>
<td>Prescription Drugs [ ] 4 4</td>
</tr>
<tr>
<td>2. Personal History of Substance Abuse</td>
<td>Alcohol [ ] 3 3</td>
<td>Illegal Drugs [ ] 4 4</td>
<td>Prescription Drugs [ ] 5 5</td>
</tr>
<tr>
<td>3. Age (Mark box if 16 – 45)</td>
<td>[ ] 1 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. History of Preadolescent Sexual Abuse</td>
<td>[ ] 3 0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Psychological Disease</td>
<td>Attention Deficit Disorder [ ] 2 2</td>
<td>Obsessive Compulsive Disorder Bipolar Schizophrenia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depression [ ] 1 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL** [ ]

**Total Score Risk Category**
- Low Risk 0 – 3
- Moderate Risk 4 – 7
- High Risk ≥ 8
CAGE-AID Questionnaire

When thinking about drug use, include illegal drug use and the use of prescription drug other than prescribed.

Questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever felt that you ought to cut down on your drinking or drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have people annoyed you by criticizing your drinking or drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you ever felt bad or guilty about your drinking or drug use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Scoring
Regard one or more positive responses to the CAGE-AID as a positive screen.

Psychometric Properties
The CAGE-AID exhibited:

<table>
<thead>
<tr>
<th></th>
<th>Sensitivity</th>
<th>Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>One or more Yes responses</td>
<td>0.79</td>
<td>0.77</td>
</tr>
<tr>
<td>Two or more Yes responses</td>
<td>0.70</td>
<td>0.85</td>
</tr>
</tbody>
</table>

(Brown 1995)
Opioid Therapy & Substance Abuse

Differential Diagnoses of Aberrant Drug-Related Behavior

- Addiction vs. Pseudo-addiction vs. Pseudo-tolerance
- Psychiatric disorders
  - e.g. borderline personality disorder
- Cognitive disorders
  - E.g. mild encephalopathy
- Family issues
- Criminal intent
Monitoring Aberrant Drug-Related Behaviors:
2-Step Approach

Step 1:
Are there aberrant drug-related behaviors?

Step 2:
If yes, are these behaviors best explained by the existence of a substance use disorder?
Aberrant Behaviors: Strategies

- Frequent visits & small quantities
  - 1 Prescriber & 1 Pharmacy
- NO replacements or early scripts
- Long-acting drugs with no rescue doses
  - No access to meds for breakthrough pain
- Use of random UDTs
- Coordination with sponsor, program, psychotherapist, others
- Consultation with addiction medicine specialist
- Prescription Drug Monitoring Programs (PDMP)
- Medication agreements
Patient Care Agreements

• Widely used but not evidence based
• Reminder: opioids → one modality in multifaceted approach to achieving goals of therapy
• Detailed outline of procedures & expectations
• Prohibited behaviors, & grounds for taper or DC
• Limitations on prescriptions
• Emergency issues
• Refill & dose-adjustment procedures
• Exit strategy
• May contain elements of Informed Consent
**Physical**
- Back exercises
- Aerobic exercise

**Behavioral**
- Stress management
- Mental Health

**Pharmacotherapy**