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Screening for Opioid Abuse Potential

Chronic pain, whether cancer-related or nonmalignant, is an immense medical problem in our society. More than 70 million Americans have chronic pain, which leads to enormous demands on medical services and on vocational and other forms of disability, as well as untold social, familial, and personal consequences.¹⁻⁵ With the advances that have been occurring in pain management, many more patients have received benefits from some form of treatment. This improvement has been especially true of pharmacological treatments, such as the wider use of opioids in the treatment of noncancer pain and the emergence of many new adjuvant analgesic drugs.

However, disillusionment about opioid therapy, and about pharmacological treatment in general, has grown among some practitioners.⁶⁻⁷ In addition to fears of regulatory scrutiny, many clinicians have doubts that we believe have a lot to do with the fact that opioids have been used alone in many instances in which a more comprehensive plan was needed, but was neither available nor feasible. When such patients then have a less than optimal outcome—whether that takes the form of addiction, misuse, diversion, or simply poor efficacy—the practitioner is likely to grow uncomfortable with a therapy that is controversial and complicated.

Today, many clinicians seek greater balance and more tempered and realistic expectations of the benefits of this aspect of pain management. As pain experts know, the population of patients with persistent pain is tremendously diverse, with some subgroups requiring a wide variety of strategies to allow them to realize the benefits of opioids and other interventions. Some patients will do well with opioids alone. For these relatively uncomplicated patients, the revolution in prescribing has brought improved access to an economical and effective intervention. But, because pain occurs in complicated human beings and complicates its own presentation with the depression and other negative life consequences it brings, many patients require more comprehensive management and lifestyle changes. Far too often, compliance with the recommended therapies is spotty at best, and completely disregarded by the patient at worst. This noncompliance may stem from a multitude of sources, ranging from poor goal setting to inertia with regard to making changes in lifestyle, or self-defeating attitudes toward problems of addiction and abuse on the part of practitioners who then fail to use therapeutic approaches to contain such problems.

The Goals of Pain Management Today

What is the goal of chronic pain management? Is it to feel better? Function better? Do doctors and patients agree on these points? There is a dearth of literature on how patients set goals for pain management, and whether or not they and their pain providers see eye-to-eye on them. It is known that cancer pain patients are often satisfied with low levels of pain relief, but we are just beginning to understand that the denominator in this satisfaction equation includes a

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complex combination of expectations, relationship issues, previous experiences with relief of pain, and goals of care.⁸⁻⁹ Perhaps patients with cancer pain feel that less pain relief is acceptable in exchange for minimizing their intake of drugs for fear of addiction and side effects. Little is known about these issues in chronic noncancer pain. Some patients will realize functional gains (such as returning to jobs that they love) with low levels of pain relief. Others will maintain that they cannot function (such as returning to jobs that they loathe) until they get nearly 100% pain relief. Overall, there is little doubt that it would be hard for a patient to understand the need for exercise, psychotherapy, pacing, and smoking cessation as parts of a pain treatment program unless they understand their pain management goals.

We must have a solid understanding of the goals of pain management for both the professional and patient before the first prescription is ever written. The goal of pain management is not simply pain relief measured on a 0–10 scale, just as the goal of diabetes therapy is not simply lowered blood sugar. As all pain experts know, the goal of chronic pain management is to enable people with pain to live a full and rewarding life in the face of chronic illness, a life in which it is possible to set and accomplish one's goals. We must be able to have this basic understanding so that we can effectively screen our patients to accomplish some risk stratification while also realizing that some of the patients seemingly at higher risk may simply have a poor baseline understanding of these goals.

Patient Prescreening Efforts

Potential opioid use must be accompanied by risk stratification and management. This process begins with an assessment of addiction risk, which can be very brief or might entail a comprehensive psychiatric evaluation. Given time constraints, time-sensitive measures are clearly needed to help in this endeavor. However, until very recently, there were nearly no validated screening tools for the prediction of aberrant behaviors in pain patients. The acknowledgment of this need has led to a substantial increase in addiction-related screening tools. A more comprehensive listing has been undertaken elsewhere,¹⁰ but we have highlighted several of the available instruments below. Many screening tools contain items on personal and family history of addiction as well as other history-related risk factors, such as pre-adolescent sexual abuse, age, and psychological disease. Some of the tools are particular to pain management, whereas others simply assess risk factors for addiction in general.

The rather sudden and large volume of tools available is both a blessing (in that we have choices) and a curse (in that it is sometimes difficult to determine which is most applicable to a particular practice). Some of the most promising instruments are highlighted here, but it must be remembered that these are tools for clinical decision-making and should not be viewed as necessarily diagnostically accurate. Whatever tool the clinician chooses, it is advised that he or she present the screening process to the patient with the assurance that there are no answers that will negatively influence effective pain management.

Drug Abuse Screening Test (DAST)

The Drug Abuse Screening Test (DAST) is a 28-item yes-or-no self-report questionnaire.¹¹ Traditionally a cutoff score of 6 is used to indicate drug abuse or dependence,

but this score can be changed to accommodate the needs of different clinical settings. In addition to the full version, which might be too long for some clinics, several abbreviated versions of the DAST can be used, based on either 10 or 20 items. The full-length DAST has face validity and high test-retest reliability, with a correlation coefficient of 0.85, and good internal consistency, with Cronbach's alpha coefficients ranging from 0.92 to 0.94. It exhibits good sensitivity in ranges from 81% to 96%, and its specificity ranges from 71% to 94%. While there are positive aspects to the DAST, it should be noted that the test and retest are only separated by a few weeks, which might make the psychometrics look artificially better than they are. In addition, the tool is susceptible to deception, and it may not identify substance abusers who intentionally give false responses. Also, the measure has yet to undergo a major validation trial in pain patients. Finally, while it predicts substance abuse, it does not specifically explore aberrant behavior during pain treatment.

Screening and Opioid Assessment for Patients with Pain (SOAPP)

Slightly shorter than the DAST, the Screening and Opioid Assessment for Patients with Pain (SOAPP) is a 14-item, self-report measure. It makes use of a 5-point scale (0 = never, 4 = very often) for the items, with a cutoff score of 8 used to determine risk.¹²⁻¹³ The relatively low cutoff score of 8 was chosen, in part, because individuals who believe that their responses may determine their opioid treatment may underreport their behavior, and because some patients fear their answers may be misconstrued.

The SOAPP is a worthy candidate for consideration in physician offices because it is an accurate tool for assessing abuse potential in patients being considered for opioid therapy and has good psychometric properties. However, the data from the initial efforts have been correlational and not causal in nature. In addition, very few demographic and medical data were recorded in the validation of SOAPP, raising the possibility of differences in the cutoff scores among different subpopulations. Despite this potential problem, the SOAPP has an active research program behind it and will probably function as a clinically relevant tool for years to come.

Opioid Risk Tool (ORT)

Offering one of the briefest measures available for use in risk stratification, the Opioid Risk Tool (ORT) consists of five yes-or-no self-report items that are designed to predict the probability of a patient displaying aberrant behavior when prescribed opioids for chronic pain.¹⁴ Items cover issues such as family and personal history of substance abuse, age, history of preadolescent sexual abuse, and psychological disease. Each positive response is given a score based on patient gender, and then the scores are summed, with scores in the 0–3 range associated with low risk, 4–7 with moderate risk, and 8 and over with high risk. Tested on 185 consecutive patients in a pain clinic, the tool displayed excellent discriminatory ability in both men and women, with observed c statistical values of 0.82 and 0.85.

The ORT is a very useful tool for clinicians due to its brevity and ease of scoring. By far, it is the easiest way to perform a risk assessment with a tool validated in pain patients and specifically designed to predict problematic behavior in people prescribed opioids for pain. The major

negative concerns the face-valid nature of the ORT and the corresponding susceptibility to deception. For many, this risk tool will be acceptable, but it may not be sufficient for all. For those finding this concise tool lacking, longer and more cumbersome tools will be needed.

Diagnosis, Intractability, Risk, Efficacy (DIRE)

The Diagnosis, Intractability, Risk, Efficacy (DIRE) score was designed for the physician to predict which chronic nonmalignant pain patients will experience effective analgesia and be able to comply with long-term opioid maintenance treatment. The categories include diagnosis, intractability, efficacy, and risk categories (psychological, chemical health, reliability, and social support). Scores are rated from 1 to 3, with higher scores indicating a greater possibility of successful opioid therapy. When the tool was tested on a relatively small sample of 61 patients for nearly 38 months, the results indicated high sensitivity and specificity for predicting both compliance and efficacy.¹⁵ In addition to the relatively small sample, the study was retrospective, and the patients had a variety of pain conditions. To be effective, the physician needs to take a good history and maintain a good relationship with the patient, so this tool might have better utility when used on an ongoing fashion as opposed to being used as an initial screener (see the section below). Given this caution, the tool could be extremely useful for physicians who want to avoid possible deception by the patient. The tool is easy to use: it takes less than 2 minutes on average to complete and is therefore effective for the busy physician.

Ongoing Screening and Management Paradigm

Passik and Weinreb¹⁶ discussed a useful mnemonic device for following the relevant domains of outcome for pain management. The “4 A’s” (analgesia, activities of daily living, adverse events, and aberrant drug-taking behaviors) are clinical domains that reflect progress toward the larger goal of a full and rewarding life. A successful outcome in pain therapy must provide meaningful relief, but it does not end solely with the provision of pain control. Analgesia must make a true difference in the patient’s life, and it must be accompanied by stabilization or improvement of psychosocial and physical functioning, manageable side effects (that do not compromise important areas of functioning), and acceptable drug-taking. Initially developed as a means for clinicians to monitor and document their patients’ progress, the 4 A’s are not solely intended for the clinician’s benefit. They are also useful for explaining the goals of therapy to patients and for helping them understand the larger goal of being treated in a pain management setting.

Pain Assessment and Documentation Tool

Passik and colleagues^{17–18} introduced the Pain Assessment and Documentation Tool (PADT), which tracks the 4 A’s and helps to streamline the assessment of outcomes in the patient with chronic pain. The time for follow-up visits is short, leaving little time to address all the domains of the outcome of treatment, and to discuss how to intervene in and overcome problematic behaviors and build motivation. The principle reason for time limitations is financial; pain physicians often face trading off between financial survival and the desire to “do the right thing” for their patients, such as

acting as an agent for positive change. It might take up to 30 minutes to address problematic behavior, but only 30 seconds to write a prescription. Pain clinicians face this dilemma daily and have to learn expedient ways to deal with complex matters or to delegate many of these tasks to other team members. Medication management can often monopolize all of the time the physician and patient spend together, so it was crucial that a tool be developed that could be brief while also comprehensive.

In practice, the PADT is a two-sided chart note that can be readily included in the patient’s medical record. It was designed to be intuitive, pragmatic, and adaptable to clinical situations. In the field trial, it took clinicians between 10 and 20 minutes to complete the tool. The finalized PADT is substantially shorter and should require only a few minutes to complete. By addressing the need for documentation, the PADT can assist clinicians in meeting their obligations for ongoing assessment and documentation while maintaining therapies. Although the PADT is not intended to replace a progress note, it is well suited to complement existing documentation with a focused evaluation of outcomes that are clinically relevant and address the need for evidence of appropriate monitoring.

Current Opioid Misuse Measure (COMM)

In addition to the PADT, the Current Opioid Misuse Measure (COMM) was designed for those pain patients already on long-term opioid therapy.¹⁹ A total of 227 chronic noncancer pain patients were asked to complete a 40-item alpha version of the assessment and the Prescription Drug Use Questionnaire (PDUQ) and were also asked to submit a urine sample for toxicology screening. Physicians were also asked to document any aberrant behavior by patients. A follow-up study among 86 patients with a version that contained the 17 items in the alpha version that were found to adequately measure aberrant behavior indicated that the COMM was promising as an efficient way of assessing current aberrant behavior. Further study is needed on this tool, but it holds promise as a way to assess current opioid misuse.

Supplementation of Screening Efforts with Laboratory Tests

In addition to the screening tools mentioned above, urine screening and other laboratory tests can help clinicians learn whether or not the patient is using illicit drugs and nonprescribed controlled substances. Supplementing documentation efforts with laboratory tests is important: Katz and colleagues²⁰ demonstrated that no matter how vigilant the clinician is at following aberrant behaviors, signs can be missed. They found that nearly 20% of patients deemed by expert clinicians to be taking their medicines as prescribed had a positive urine screening.

Urine screening provides a non-invasive, low-cost monitoring strategy that will detect most drugs for 1 to 3 days after exposure.²¹ In addition, urine screening can provide objective documentation of a patient’s compliance with the treatment plan and opioid agreement, reduce the risk of an unrecognized opioid abuse problem, and justify the continuation of chronic opioid analgesic therapy in patients who adhere to the treatment plan and have acceptable urine screening outcomes.²² It should be cautioned that, while urine drug screens are useful, the results are sometimes incorrect; both false positives and false negatives do occur on occasion.

In addition, some compounds are not typically found in standard urine screens, and the clinician must order more specific, expensive urine tests (or even blood or hair testing). Thus, urine test results are only one piece of the puzzle in the evaluation of whether a patient is problematic.

Conclusion

Pain management is both an art and a science. The art of pain management is the orchestrating of multiple ways of intervening, tailored to individuals. We must strive to pay more than lip service to the need for such care. And then, when we make the recommendation, it is time for us to assume the role of agents for change in our patients' lives, a role for which many pain practitioners from various disciplines can feel poorly prepared.

Treating chronic pain effectively is challenging and demands a great deal of attention and motivation on the part of the treating physician. With an eye toward aberrant behaviors and potential addiction on the one hand, and undertreatment and opiophobia²³ on the other, the treating clinician must be ever-vigilant and thorough in assessing the needs and drives of patients. Fortunately, we are at the beginning of a strong push to produce risk stratification tools for both initial assessment as well as ongoing follow-up.

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