

Managing Pain in Patients With Aberrant Drug-Taking Behaviors

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It is estimated that 6%–15% of the US population has a substance use disorder of some type [1–3]. While addiction commonly is believed to have a lower base rate among patients with cancer as compared with the prevalence of substance use disorders in our society at large [2–5], it is nonetheless a problematic issue when it arises—and it is worthy of attention. Also, the relatively low prevalence of substance abuse among patients with cancer treated in tertiary-care hospitals may reflect institutional biases or a tendency for patient under-reporting in these settings.

Of course, concurrent drug abuse and cancer pain is problematic, but there is the additional problem regarding the diagnosis and understanding of less obvious aberrant drug-taking behaviors that sometimes are seen when treating patients without formal psychiatric histories of substance use disorders. Such behaviors can manifest, for example, when a patient with cancer pain is escalating drug doses or using medications to treat other symptoms. Once these aberrant behaviors are identified, clinicians must decide on a course of action that is fair and in the best interests of the patient and their own careers.

With the pressure of regulatory scrutiny and our duty to treat pain but contain abuse or diversion, clinicians often believe that they must avoid being duped by those abusing prescription pain medications. However, the clinician attempting to diagnose the meaning of aberrant drug-related behaviors during pain management need not be correct. The clinician has an obligation to be thorough, thoughtful, logically consistent, and careful (not to mention humane and caring), but

not necessarily “right.” Indeed, there are multiple explanations in the differential diagnosis of aberrant drug-taking behaviors, with criminal intent and diversion being only one of the possibilities.

Clinical management can be tailored for the multiple possibilities that might give rise to the behaviors noted in the patient assessment, and asserting control over prescriptions can be accomplished without necessarily terminating the prescription of controlled substances entirely. In the treatment of cancer pain, clinicians do not have the same latitude to withhold pharmacology simply because of abuse concerns. The clinical, ethical, and even moral imperatives to treat pain can create difficult clinical dilemmas, especially if the patient, or a friend or family member, is abusing medications. These situations defy simple solutions.

Concerns Over Current Definitions

Tolerance and physical dependence are not necessarily signs of addiction or abuse in cancer patients with pain. In fact, physical dependence is to be expected with chronic dosing of opioids, and tolerance usually is a sign of disease progression and worsening pain [6–14].

The ability to categorize questionable behaviors (eg, consuming a few extra doses of a prescribed opioid or using an opioid prescribed for pain as a nighttime hypnotic) as outside the social or cultural norm also presupposes that there is certainty about the parameters of normative behavior. Less aberrant behaviors (such as aggressively complaining about the need for medications) more likely reflect untreated distress of some type rather than addiction-related concerns. Conversely, more aberrant behaviors (such as injection of an oral formulation) more likely reflect true addiction. Empirical studies are needed to validate this conceptualization, but this may be a useful model when evaluating aberrant behaviors.

A more appropriate model definition of addiction notes that it is a chronic disorder characterized by compulsive use despite harm [15], which appropriately emphasizes that addiction is a psychological

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Table 1

Suggestions and Sample Questions for Approaching Patients About Potentially Aberrant Drug-taking Behaviors

Take a non-judgmental stance

We think of this process as a fact-finding mission and not an inquisition of our patient. If we are successful with our approach, patients likely will be much more forthcoming, because they do not feel that they are being judged.

Start with sweeping questions

Jumping right in with tough questions about possible abuse of medications is difficult to initiate and undoubtedly will put the patient in a defensive posture from the beginning. Sweeping questions allow us to discover general attitudes toward medications and what they mean to our patients. Here are a few examples:

- What do your medications mean to you?
- How helpful have they been for you?
- Have you ever had any bad outcomes with your medications (either from side effects, your social life, or legally)?

Avoid “yes/no” style questions

Again, the goal is to help the patient open up and share their perspective. Questions that may be answered with either a “yes” or “no” create the sense of a cross examination and do not allow an opportunity for exposition. These types of questions can be used later in the conversation when necessary.

Remember, the patient is the expert in these matters

We try to take a curious and interested stance in what our patient has to say. Using the tips mentioned previously, we sometimes find patients revealing a great deal about how they use their medications and what these medications mean to them in their daily lives (ie, if the medications are a form of coping when under stress instead of a routine medicine used solely for pain).

Close in on possible problems with detailed questions about warning signs

When appropriate avenues open, we make our questions more specific as we look for signs of self-medication and chemical coping. Here are a few examples:

- Have you ever taken your pain medications for other reasons?
- Have you ever taken them to help you sleep? When under stress? After a fight with a spouse or loved one?

Examine the patient for signs of flexibility

Building on the previous step, we try to determine how central the medications are to the patient’s life. It is important to determine how open he or she is to alternate forms of pain therapy (ie, relaxation training, interventional procedures, adjuvants, etc). A patient who lives life “by the bottle” and can not see other possibilities likely is having issues with chemical coping.

Use existing questionnaires

We use measures such as the Screener and Opioid Assessment for Patients in Pain (SOAPP) and the CAGE questionnaire to augment our discussions with our patients. These measurements can be found at sites such as <http://www.painedu.org> or <http://www.npecweb.org>.

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and behavioral syndrome. Any appropriate definition of addiction must include the concepts of loss of control over drug use, compulsive drug use, and continued drug use despite harm.

The 4 A’s of Pain Management Outcomes

Learning how to recognize and document potentially aberrant drug-taking behaviors is an important first step in recognizing the existence of a problem in need of closer management. To this end, and for the relevant domains of outcome for pain management, Passik and Weinreb [16] dis-

cussed a useful mnemonic device known as the “4 A’s”: analgesia, activities of daily living, adverse events, and aberrant drug-taking behaviors. The 4 A’s remind clinicians that a successful outcome in pain therapy involves more than the lowering of pain intensity scores. The 4 A’s reflect a therapy that offers pain relief that makes a true difference in the patient’s life, stabilizes or improves psychosocial functioning, manages side effects, does not compromise important areas of functioning, and provides an intact mechanism to assess and control aberrant behaviors. Nowhere is there a need for greater understanding and enhanced assessment ability than in this final domain of aberrant drug related behaviors.

Clinical Management

Out-of-control aberrant drug-taking among palliative-care patients represents a serious and complex clinical occurrence. The principles outlined herein help the clinician establish structure, control, and monitoring so that he or she can prescribe freely and without prejudice.

First, a multidisciplinary team approach is recommended for the management of substance abuse in the palliative-care setting. Mental health professionals who specialize in addiction therapy may be instrumental in helping palliative-care team members develop strategies for management and treatment compliance. Second, the first member of the medical team (frequently a nurse) to suspect problematic drug-taking or a history of drug abuse should alert the patient’s palliative-care team, thus beginning the assessment and management process [17], which includes use of empathetic and truthful communication (see Table 1 for suggestions and sample questions). This approach entails starting the assessment interview with broad questions about the role of drugs (eg, nicotine, caffeine) in the patient’s life and gradually becoming more specific to include illicit drugs.

Third, the development of clear treatment goals is essential in managing drug abuse, although the distress of coping with a life-threatening illness and the availability of prescription drugs for symptom control may make complete abstinence an unrealistic goal [18]. Rather, a harm-reduction approach should be used. A written agreement between the team and patient provides structure to the treatment plan, establishes clear expectations, and outlines the consequences of aberrant

Table 2
Key Elements of an Opioid Agreement

<p>Understand that there is no universally accepted opioid agreement Many examples, including one referenced in the footnote of this table, can be found via the Internet, but no definitive version exists. However, the following features are some that an agreement should contain.</p>
<p>Explain the expectations of the patient In clear and concise language, we make it known that the patient has a stake in his or her own care and is not simply a passive participant. The agreement should be written with flexibility and avoid ultimatums if transgressions are found. Ultimatums serve only to limit the choices the physician can use in the light of problematic behaviors. If an ultimatum is listed, and not followed through for an “exception,” the agreement will lose all meaning and forever be subject to having its boundaries tested by the patient.</p>
<p>Explain the role of the physician This is a relationship, and the document should explain the role of the physician and healthcare team. The agreement can spell out important issues, such as:</p> <ul style="list-style-type: none"> • Medications will be provided by a single provider. • Medications will be prescribed on a “round-the-clock” schedule. • Lost or stolen medications will not be replaced.
<p>List risks and benefits of the proposed therapy We list issues with the medications, such as their ability to create physical dependence and tolerance, the potential for addiction, and the warning signs of addiction.</p>
<p>Designate a single pharmacy It is important to keep the treatment as streamlined as possible to eliminate both intentional and unintentional sources of confusion on the part of the patient. The patient should be able to pick the pharmacy of his or her choice but must stick with it to maintain a consistent relationship.</p>
<p>Provide a rationale for your policies We try to be flexible in setting policies, but we recognize the importance of explaining why certain policies exist (ie, “If we see you engaging in certain behaviors—such as consistently requesting early renewals—it is a warning sign to us that might indicate you are having a problem controlling your medication usage.”)</p>
<p>Get consent for the treatment and testing In our practice, both the physician and patient must sign the document. It is also necessary to have a consent in the document that clearly spells out the types of testing that might be done (ie, random urine toxicology screens, pill counts, etc) in the course of treatment.</p>

A prototype of an opioid agreement can be seen at <http://www.painedu.org/Downloads/NIPC/Sample Patient Treatment Agreement.pdf>. Also, readers may be interested in the following in-depth treatments of opioid agreements:

Fishman SM, Mahajan G, Jung SW, Wilsey BL. The trilateral opioid contract: bridging the pain clinic and the primary care physician through the opioid contract. *J Pain Symptom Manage* 2002;24:335–344.

Fishman SM, Kreis PG. The opioid contract. *Clin J Pain* 2002;18(4 suppl):S70–S75.

drug-taking (see Table 2 for the key elements of an opioid agreement). The inclusion of spot urine toxicology screens and pill counts in the agreement can be useful in maximizing compliance (see Table 3 for tips on ordering urine toxicology screens).

Fourth, the team should consider using longer acting drugs (eg, fentanyl patch (Duragesic), sustained-release opioids). The longer duration and slow onset may help reduce aberrant drug-taking behaviors when compared with the rapid onset and increased dosage frequency associated with short-acting drugs. Fifth, the team should plan to reassess the adequacy of pain and symptom control frequently.

Finally, the team should involve family members and friends in treatment to help bolster social support and functioning. Becoming familiar with

the family may help the team to identify family members who are drug abusers and who potentially may divert the patient’s medications and contribute to the patient’s non-compliance. Although this level of teamwork creates challenges for physicians and medical staff, ultimately, success and its rewards may be seen with these difficult patients. The following case example highlights such an outcome.

CASE EXAMPLE

F. D. was a 39 year-old man with pancreatic cancer. He was not a candidate for surgical resection, and after he decided to forego chemotherapy and radiation therapy, he was referred to the palliative care program. The patient had presented with advanced disease and a 40-pound weight loss. He had been suffering with abdominal pain

Table 3**Tips for Ordering Urine Toxicology Screens****Get a detailed history on the medications prescribed to the patient**

We ensure that our records are current on all of our patient's medications before sending a urine toxicology screen. Up-to-date records help to prepare for the expected results and to order any specific tests we might desire.

Know your lab

It is worthwhile to establish a relationship with the lab where specimens are sent. This facility can be an invaluable resource for helping us determine what tests are needed and the cutoff levels used for various substances.

Be careful with false negatives

We find it disturbing to order a urine screen and find a negative result for a particular opioid we are prescribing to the patient. However, as mentioned previously, it is important to know the cutoff levels employed by the lab as well as whether they even can test for the drug of interest (eg, fentanyl is not commonly found in urine).

Be careful with false positives

Our knowledge of the lab's cutoff values helps us determine which drugs might show up as metabolites of others in testing.

Talk with the patient

We ask the patient if any illicit or other substances will be in his or her urine. Aberrant findings in urine should not be used to dismiss patients outright, but are useful as a check of the honesty and level of communication the patient has with us. We engage them around the topic of urine drug screens as an opportunity to work on any problems he or she might be having with loss of control or abuse of their treatment.

Readers interested in learning more about urine toxicology screening should read the work of Gourlay, Heit, and Caplan on urine testing in primary care. It can be viewed at: <http://www.familydocs.org/UDT.pdf> (Accessed 12/08/04).

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for months but was self-treating with sustained release oxycodone (OxyContin) that he had been abusing and dealing illegally for the last several years. The patient had a very limited life expectancy when first evaluated, and he was not open

to considering other opioids or celiac plexus nerve blocks. He stated that he just wanted to be comfortable enough to play with his three-year-old daughter until he died. The patient always required high doses of medication for comfort (800 mg of sustained-release oxycodone twice per day) as well as adjuvant analgesics and corticosteroids. He had remarkably good pain and symptom management until his death, allowing him to go deer hunting just 2 weeks before he died. The provision of supportive care would have been impossible without the structure provided by hospice nurses, who delivered 1 day's worth of medicine at a time, turned up randomly for pill counts at the patient's home, collected urine for toxicology screens, and otherwise coordinated tremendous levels of support from those family members who had been assessed and deemed not involved with illicit drug use and sales.

Conclusion

Managing addiction problems in patients with cancer is labor-intensive and time-consuming. Clinicians must recognize that virtually any centrally-acting drug, and any route of administration, is a potential target for abuse. The problem does not lie in the drugs themselves. The effective management of patients with pain who engage in aberrant drug-taking behavior necessitates a comprehensive approach and provides practical means to manage risk, treat pain effectively, and assure patient safety.

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