Opioid Therapy: Managing the Risk of Substance Abuse

Opioid therapy is the mainstay approach for the management of moderate to severe chronic pain and moderate to severe chronic dyspnea in populations with life-limiting illnesses. Whenever a primary care provider considers ongoing, long-term treatment with an opioid—whether or not short-term treatment is occurring, and whether or not the patient has advanced illness—it is an opportunity to initiate a strategy of **UNIVERSAL PRECAUTIONS**. This strategy addresses the potential for adverse "substance abuse outcomes" whenever opioids are prescribed.

UNIVERSAL PRECAUTIONS include: 1) risk assessment, 2) a decision to either prescribe or not, or to risk stratify and then prescribe, 3) risk mitigation by adherence monitoring consistent with the level of risk, 4) monitoring of drug-related behaviors, and 5) appropriate response to problematic incidents.

It is valuable to approach the patient with openness about the strategy: "We do these things so that we can verify what is happening with these drugs, so that we can always act in your best interests." Ongoing documentation of the strategy is important. ***Remember: Opioid therapy may be stopped at any time when the assessed risk of treatment exceeds the benefit.***

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Steps to Follow in a Universal Precautions Approach to Opioid Prescribing

	Strategies	Comment
1. Assess risk for opioid misuse	**History from patient and record review** • **Most important for risk stratification** ▪ Personal history of alcohol or drug abuse ▪ Family history of alcohol or drug abuse ▪ Any major psychiatric disorder • **Other important factors** ▪ Younger age ▪ History of sexual abuse ▪ History of smoking ▪ Unstable social/family situation ▪ Involvement with drug abuse culture • Review of Prescription Drug Monitoring Program data • Consider screening questionnaires • Consider biofluid (e.g., urine or saliva) drug screening	• All patients should undergo risk assessment • Many questionnaires are available but clinical assessment is generally used • Outcome of risk assessment: **Either 1) a decision to not prescribe, or** **2) a decision to risk stratify and prescribe**
2. Consider whether to prescribe or not	**Risk of diversion as a contraindication to prescribing:** • **Low risk ⟶ no contraindication** • **High risk** and reasonable alternative treatment exists ⟶ **strong contraindication** • **High risk**, no reasonable alternatives, ***and*** controls and adherence monitoring can be established to ensure that diversion is not occurring ⟶ **relative contraindication** • **High risk**, no reasonable alternatives, ***and*** there is no way to ensure no diversion ⟶ **strong contraindication** **Drug abuse risk as a contraindication to prescribing:** • **Low risk ⟶ no contraindication** • **Moderate or high risk** ▪ Consider: Are there reasonable alternative treatments? How severe is the drug abuse risk (e.g., risk of relapse of heroin addiction vs. risk of early refill requests)? Can the risk be limited by adherence monitoring? ▪ **Examples of decision making:** – **High risk**, reasonable alternatives, ***and there is no way to effectively mitigate risk*** ⟶ **strong contraindication** – **Moderate or high risk**, no reasonable alternatives, ***and risk can be mitigated*** ⟶ **low relative contraindication**	• The first goal of risk assessment is to decide whether or not the risk of diversion or drug abuse is too high to justify prescribing. • Risk of diversion may be so low that it is not a contraindication, or it may be a relative contraindication, with strong enough clinical need for treatment that the risk is worth taking. • **If the risk of diversion is high and unmodifiable, do not prescribe**. • Risk of drug abuse may be so low that it is not a contraindication or it may be a relative contraindication with strong enough clinical need for treatment that the risk is worth taking. • **If the risk of drug abuse is not very low, the decision to prescribe or not should consider a variety of factors. *With high and unlikely to be modifiable risk, it is acceptable to not prescribe; with manageable risk and strong clinical indication, it is difficult to justify not prescribing.***

Steps to Follow in a Universal Precautions Approach to Opioid Prescribing *continued*

	Strategies	Comment
3. Risk mitigation	**Structure treatment to:** • Establish an appropriate level of adherence monitoring. • Help patients who are at risk avoid non adherence.	**The following are elements that may or may not be used in adherence monitoring:** • Detailed interviewing about drug-related behavior ▪ Questioning of family members and record review from other treating physicians ▪ Check of prescription monitoring program, with or without required use of a single pharmacy ▪ Check of biofluid (urine or saliva) drug screen ▪ Small and frequent prescriptions ▪ No prescribing of multiple opioids (e.g., no drug for breakthrough pain) ▪ Use of drugs with low street value (e.g., methadone, transdermal fentanyl) ▪ Pill counts ▪ Mandatory consultations with psychiatry or addiction medicine • **When risk is low**, adherence monitoring may be limited to interview and check of prescription monitoring program. • **As risk increases**, more elements should be added.
4. Monitor drug-related behaviors	• Effectiveness ▪ Pain control ▪ No drug-related adverse effect on physical or psychological functioning • Side effects • **Adherence monitoring**	**Adherence monitoring means evaluating a broad range of drug-related behaviors.** • Includes behaviors that have indeterminate meaning, such as verbal statements about craving • Includes behaviors that appear on the surface to be relatively non-serious, such as occasional use of an extra dose, requesting an occasional early refill • Includes behaviors that are worrisome, such as obtaining a partial refill early from another physician • Includes behaviors suggestive of addiction, or serious drug abuse, such as unsanctioned dose escalation despite warnings or clear doctor shopping, or use of illicit substances • Includes behaviors suggestive of diversion, such as a negative drug screen during treatment

	Strategies	Comment
5. Respond to incidents	• **Reassess and diagnose.** • **Consider whether to continue prescribing.** • **If prescribing continues, restructure treatment to increase monitoring, and control over prescribing, consistent with the seriousness of the incident.**	• When aberrant drug-related behaviors occur, reassessment is needed to establish a diagnosis. The following possible diagnoses are not mutually exclusive: ▪ Addiction ▪ Other psychiatric conditions associated with impulsive drug use, e.g., anxiety disorder, personality disorder ▪ Family issues ▪ Desperation or impulsivity driven by uncontrolled pain ("pseudo-addiction") ▪ Diversion • If diversion is occurring, prescribing should stop. • If diversion is not occurring and the benefits of therapy outweigh the risk of continuing therapy, additional evaluation, treatments and elements of adherence monitoring should be considered.

Adapted from Portenoy RK and Ahmed E, Principles of opioid use in cancer pain. J Clin Oncol. 2014; 32(16):1662-1670, and Portenoy RK, Treatment of cancer pain. *Lancet.* 2011 377:2236-2247.

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