ABERRANT DRUG-TAKING BEHAVIORS: WHAT DO WE KNOW?

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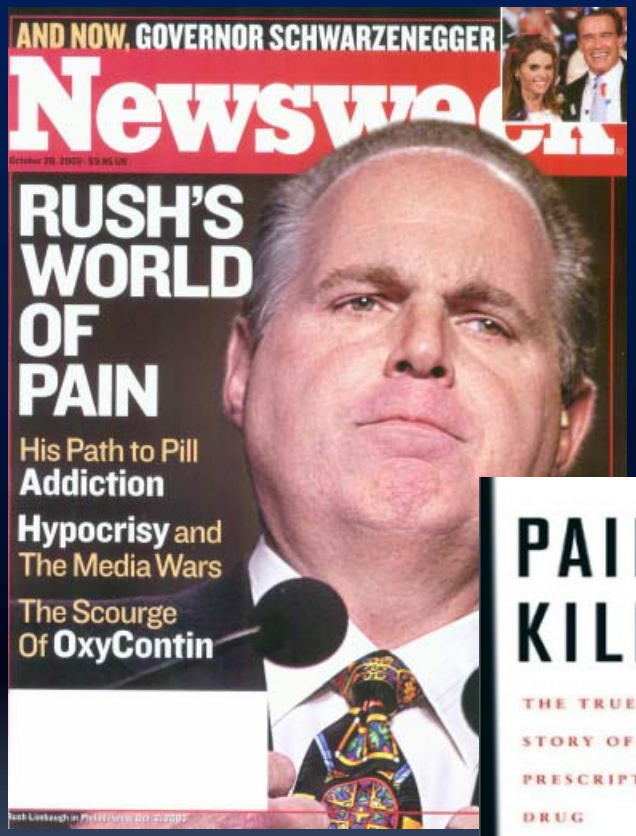
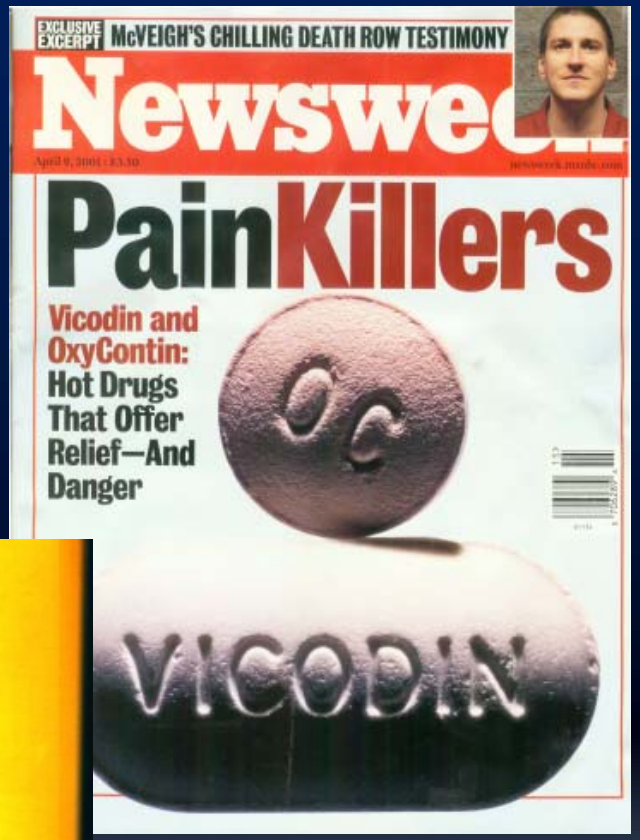
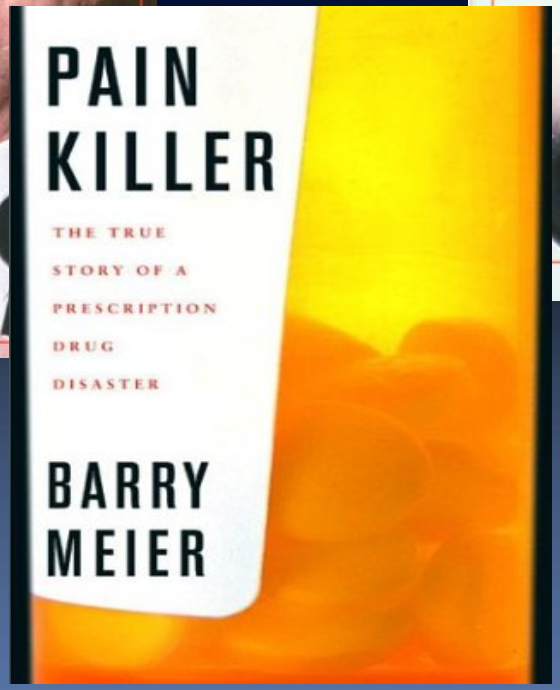
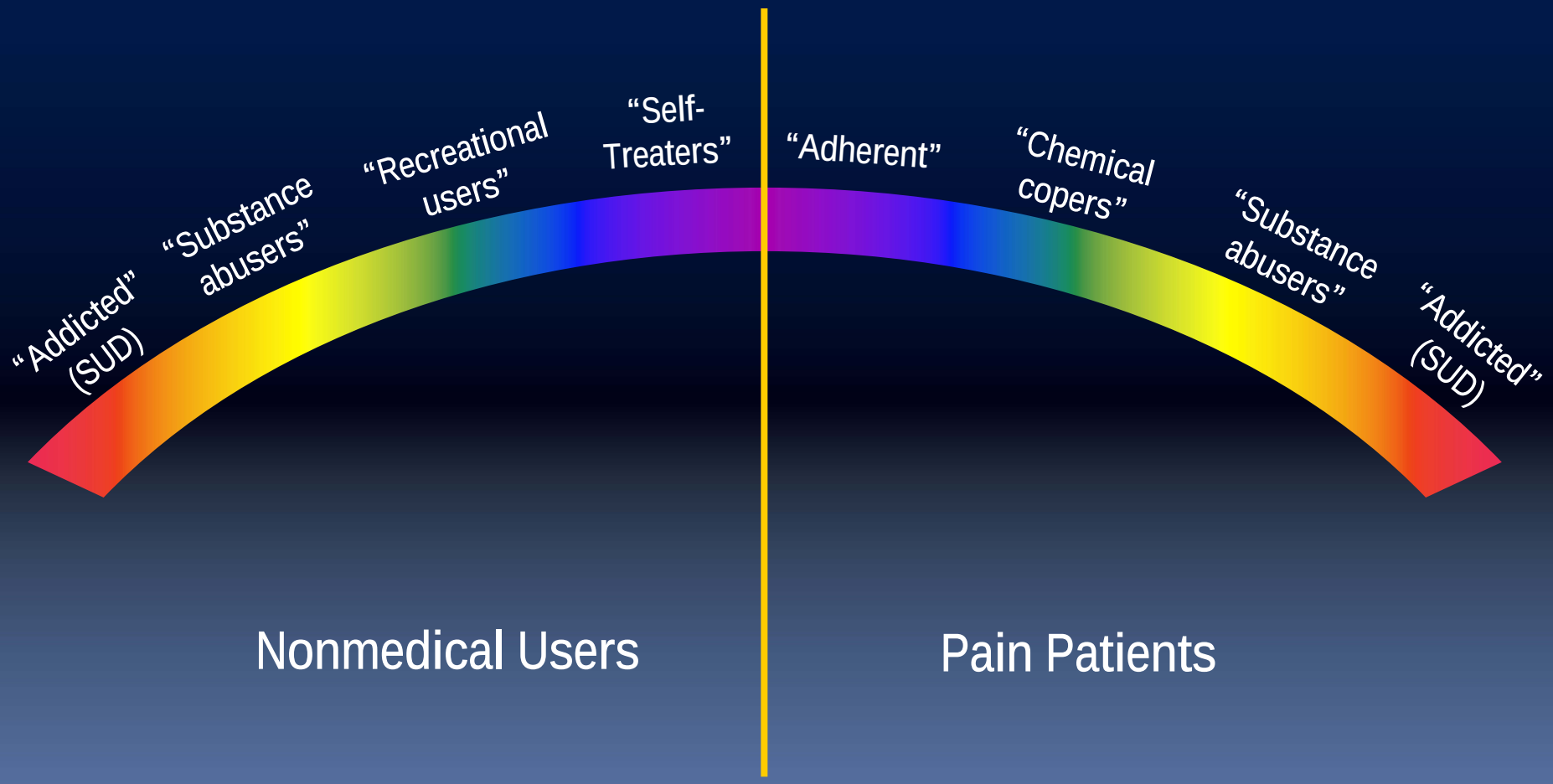
The OxyContin Story



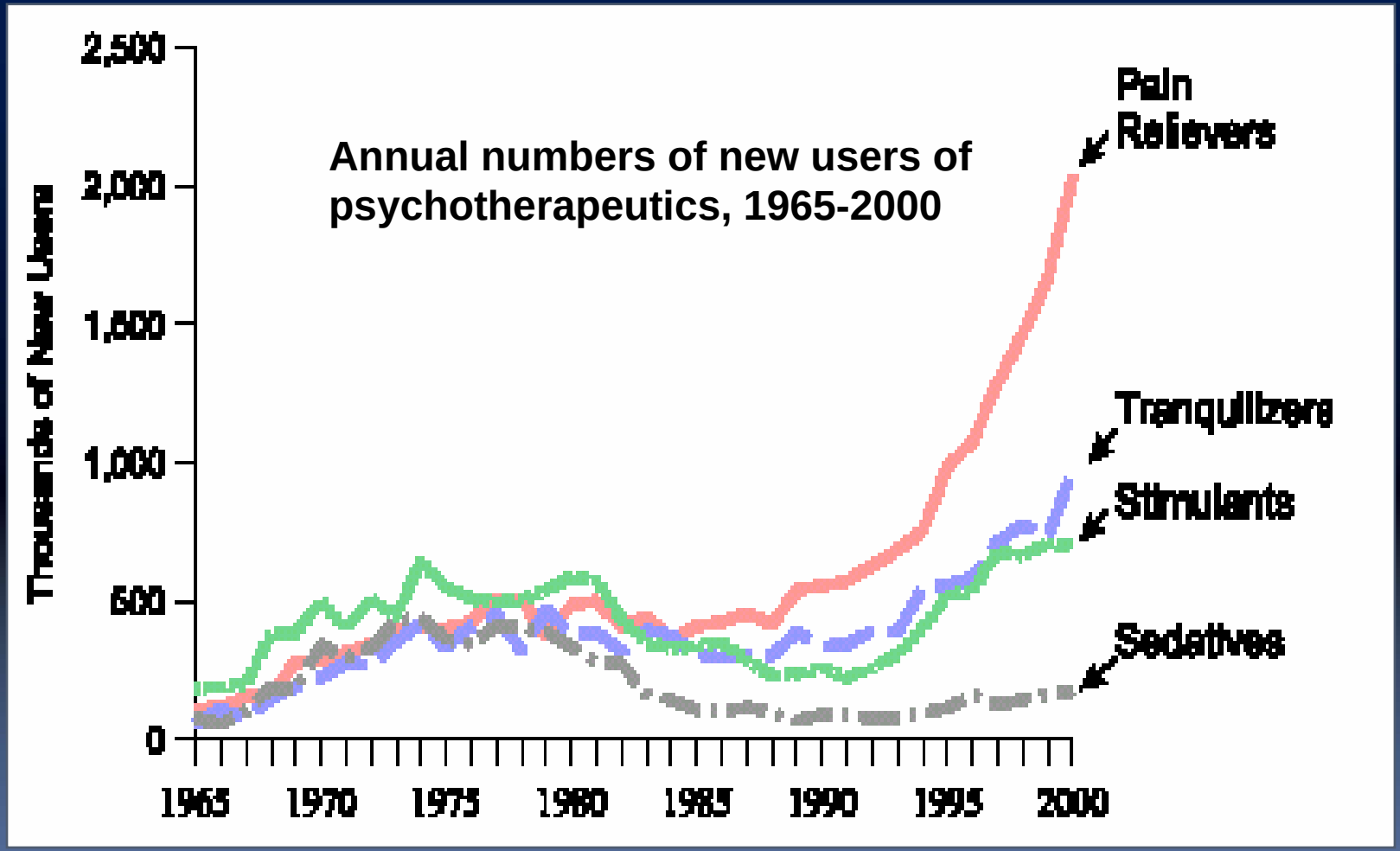




Population of Rx Opioid Users Is Heterogeneous

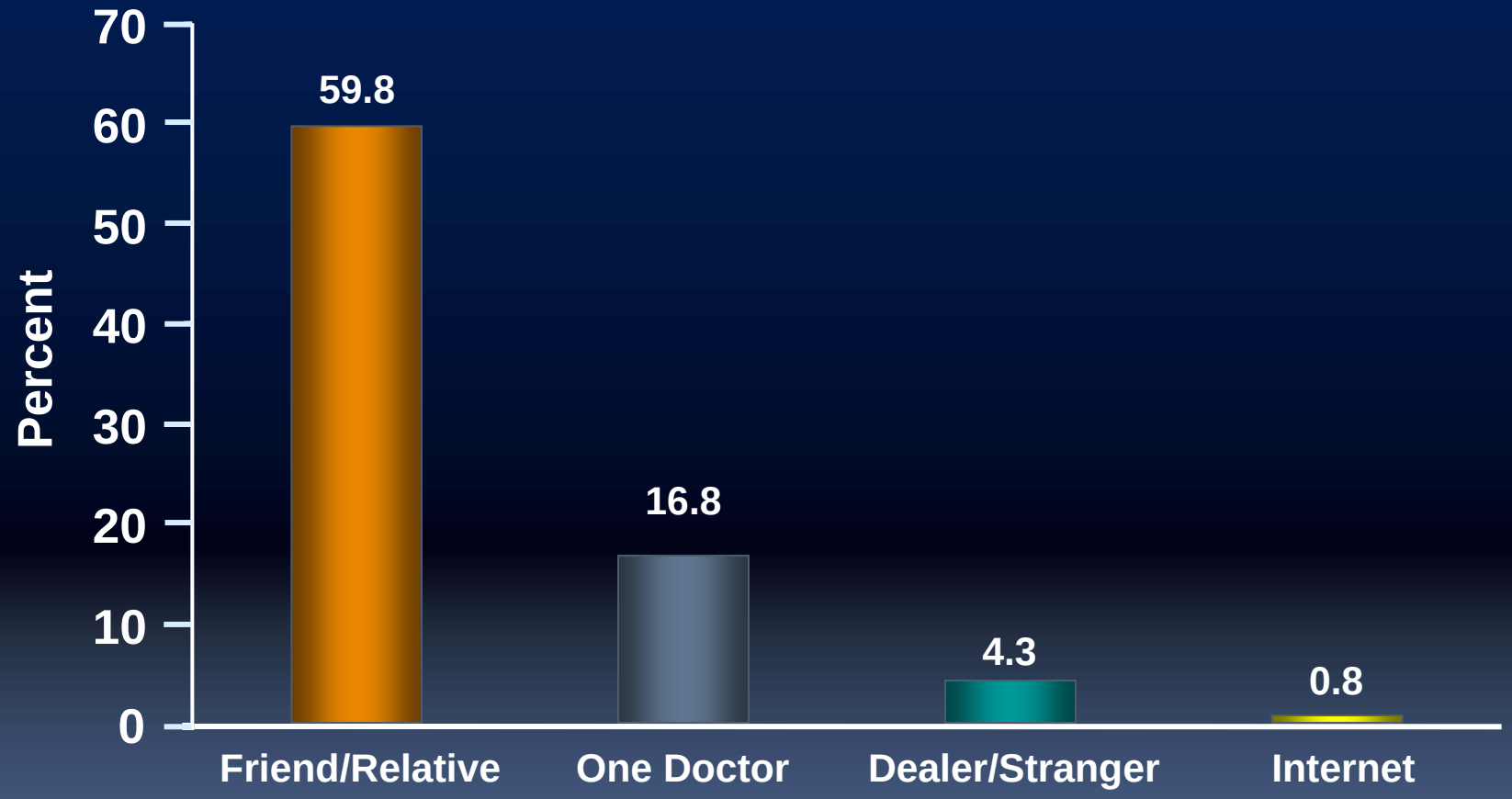


Use of Psychotherapeutic Agents



NHSDA, 2002

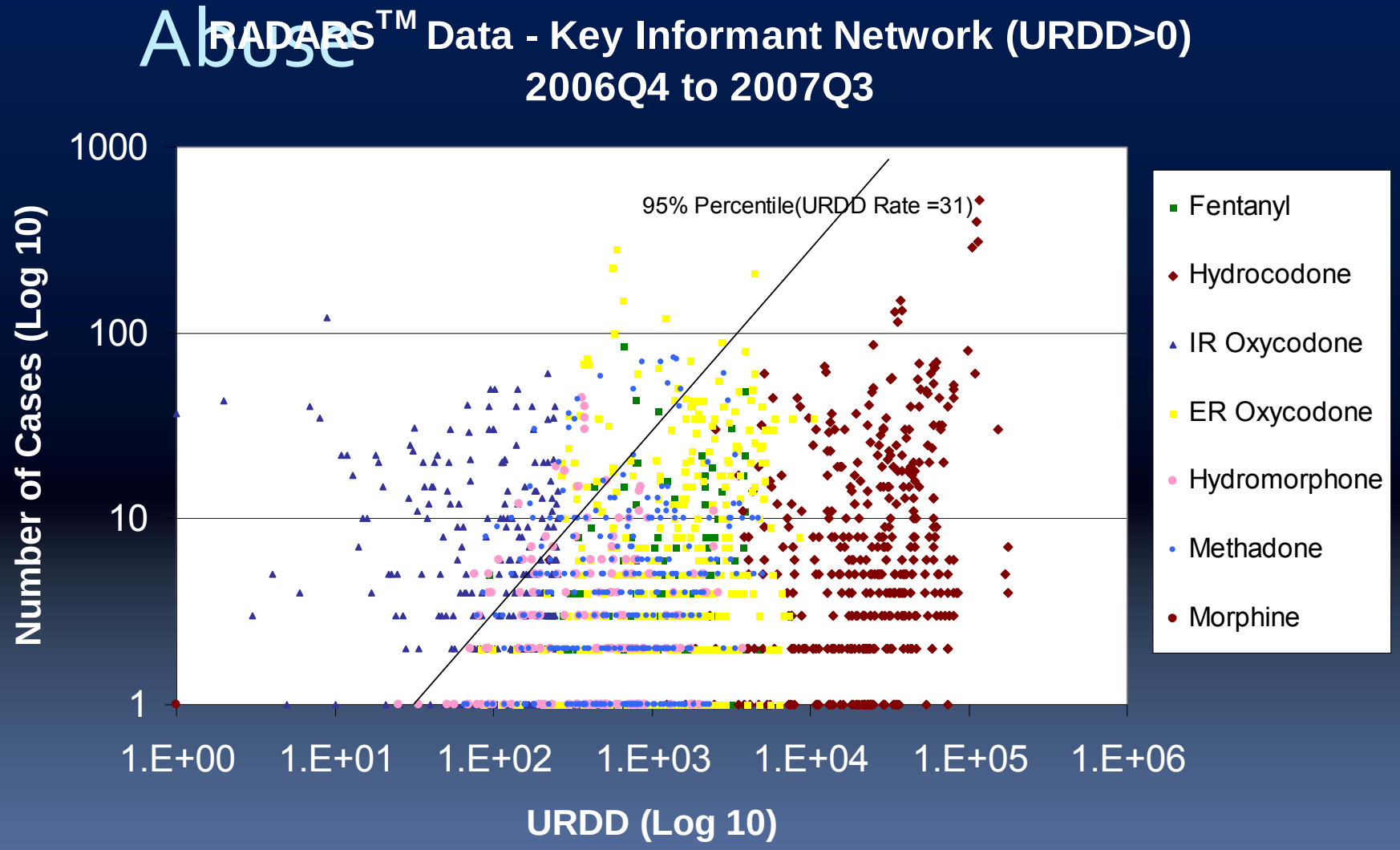
Pain Relievers Obtained for Nonmedical Use: Sources Reported by Users*



*Source of drugs for the most recent nonmedical use of pain relievers reported by persons aged 12 or older in the United States 2005.

SAMHSA. *Results From the 2005 National Survey on Drug Use and Health.* DHHS Publication No. SMA 06-4194, 2006.

Relationship Between Use & Abuse



Cicero, T.J., et al. *Pharmacoepidemiol Drug Saf.2007:16;827-840.*

Non-Medical Users and Pain Patients Are Not Always Distinct Groups

- 491 admissions to Addictive Disease Unit in 15-month period
- **258** (52.5%) admitted for abuse with prescription opioids
  - 169 men, 89 women
  - 219 rural, 39 urban
  - Mean age – 34 (SD 10.6)
- 162 (62.8%) for OxyContin, 96 (37.2%) for any other opioid

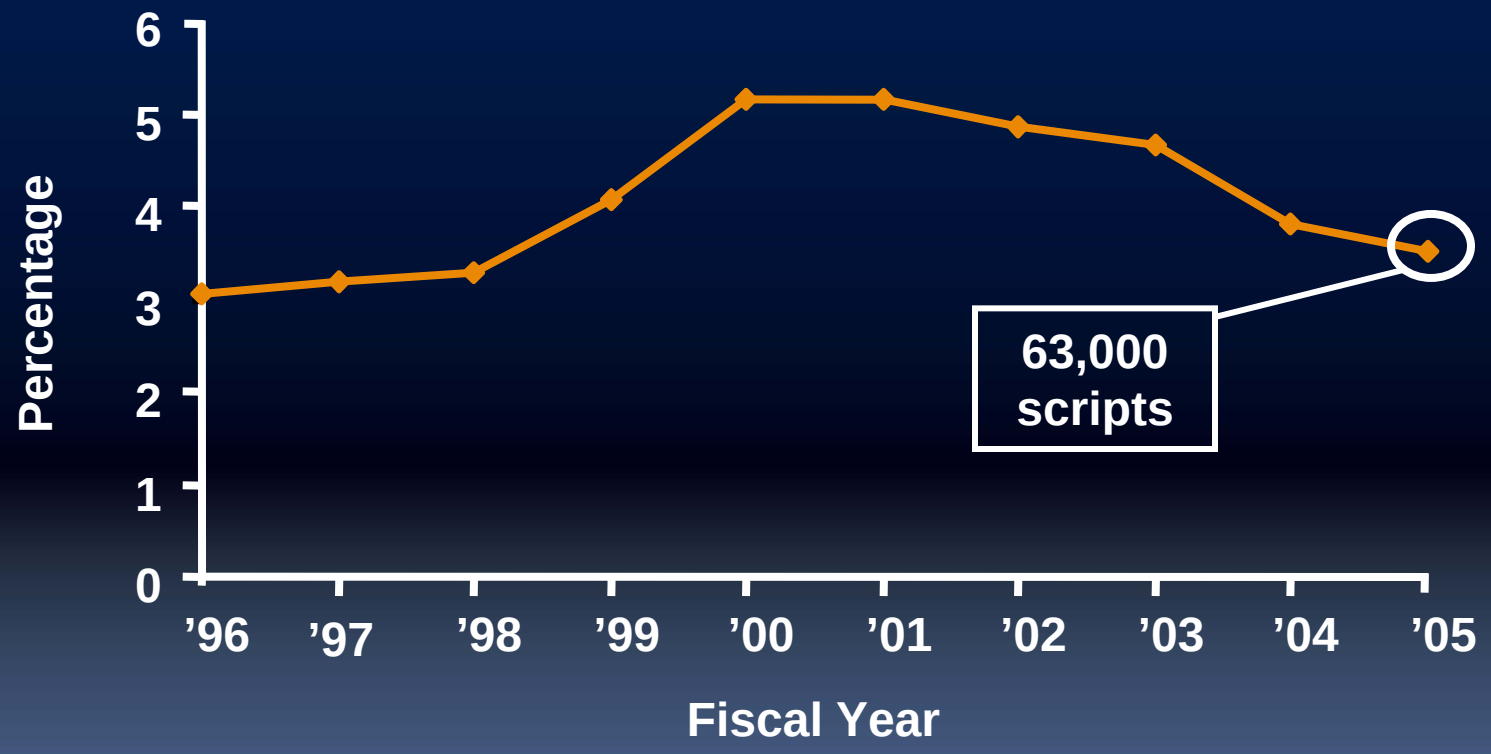
Hays, Kirsh Passik. JNCCN, 2003;1(3):423-428.

Non-Medical Users and Pain Patients Are Not Always Distinct Groups

- Profile:
  - 117 men, 45 women
  - Mostly rural (n = 148, 91.4%)
- Majority admitted to buying on the street (n = 160, 98.8%)
- Only 48 (29.6%) had ever obtained it through legitimate Rx
- 78 (48.1%) also used other opioids (either hydrocodone products or methadone)
- **Mean dose:** 181.3 mg for average of 19.7 months
- Administration (initial): oral (82%), snorting (16%), IV (1%)
- Administration (admission): snorting (58%), IV (21%), oral (21%)

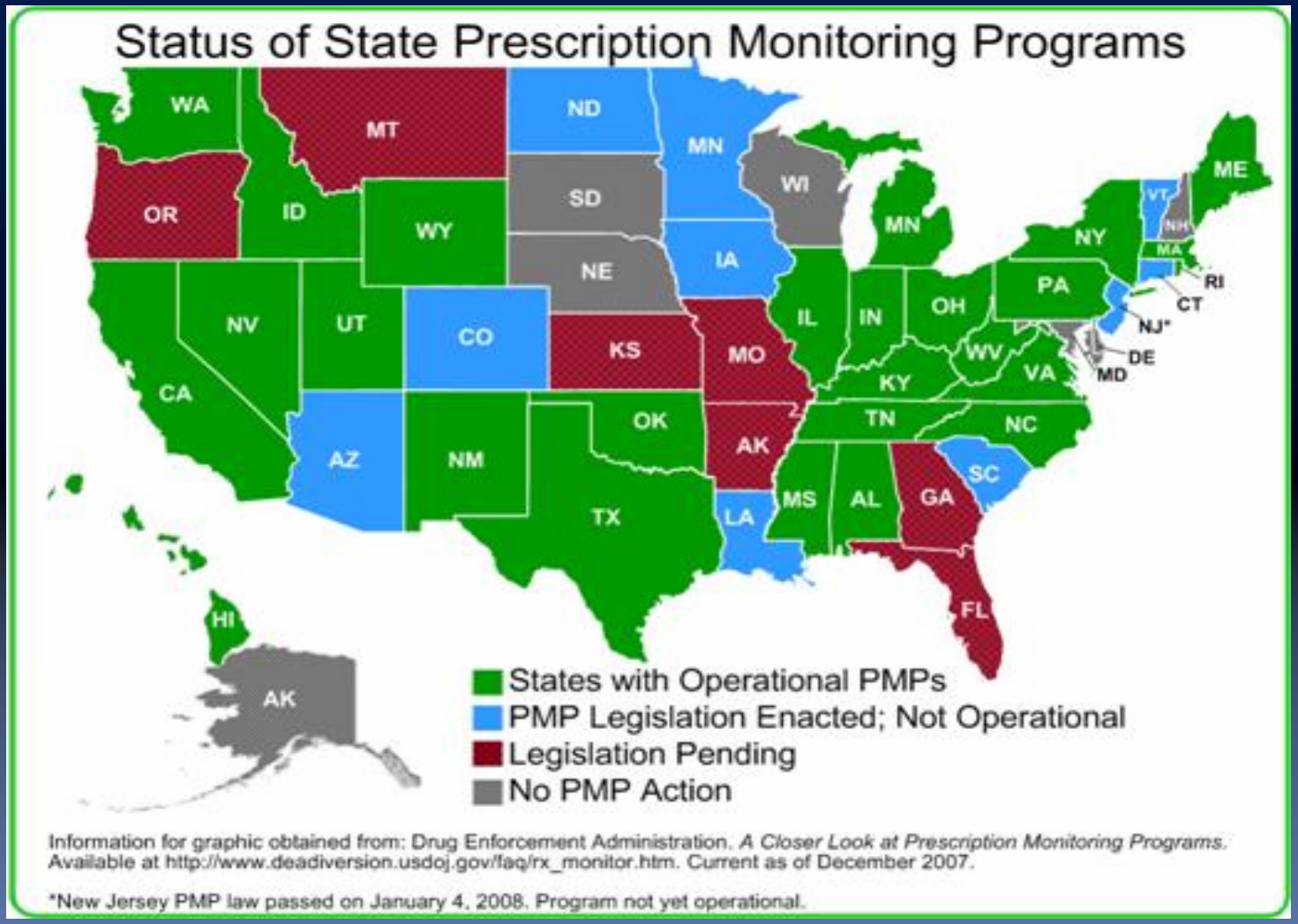
Hays, Kirsch Passik. JNCCN, 2003;1(3):423-428.

Estimated Percentage of Schedule II Opioid Prescriptions Dispensed to Individuals Showing Questionable Activity* by Fiscal Year



*Questionable Activity = obtained Schedule II opioid prescriptions from ≥4 pharmacies and ≥4 physicians during the specified year.

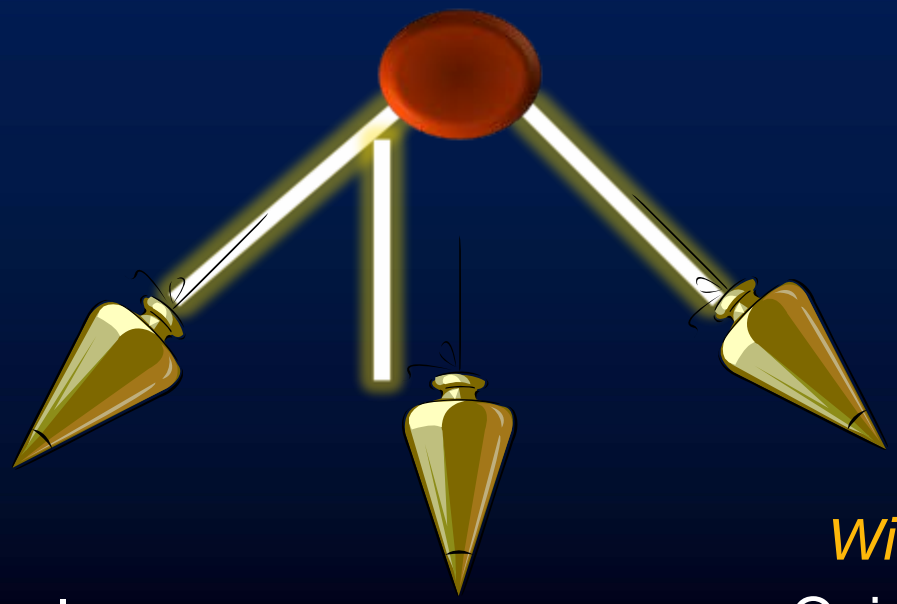
Prescription Monitoring Programs



Information for graphic obtained from: Drug Enforcement Administration. *A Closer Look at Prescription Monitoring Programs.* Available at http://www.deadiversion.usdoj.gov/faq/rx_monitor.htm. Current as of December 2007.

*New Jersey PMP law passed on January 4, 2008. Program not yet operational.

The Opioid Pendulum



Avoidance

Even dying people at risk of addiction

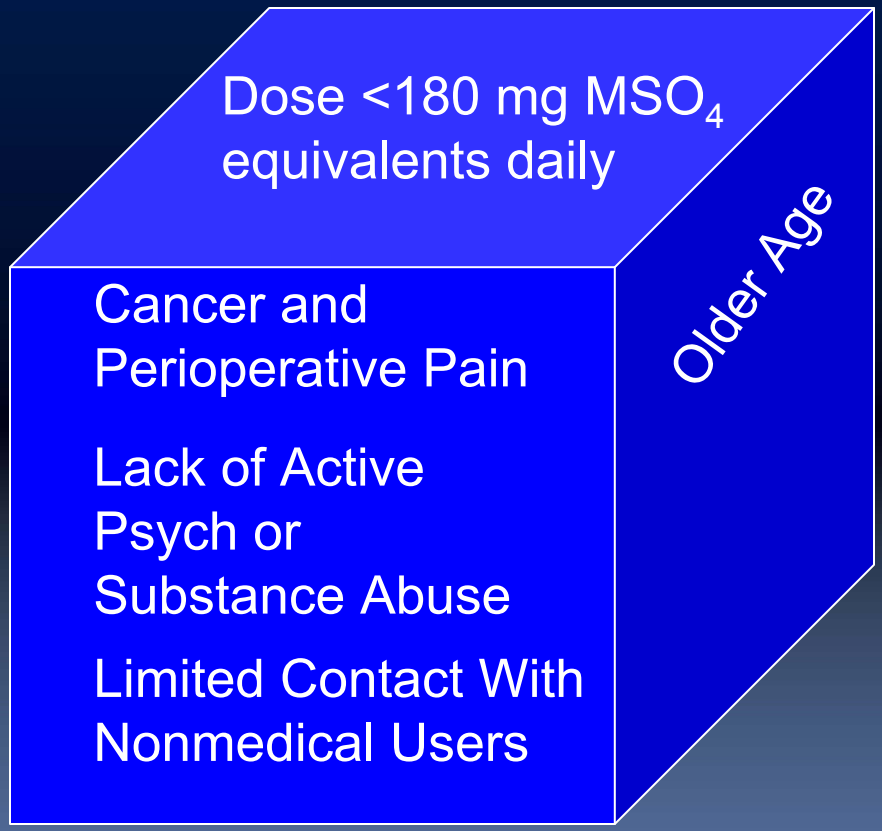
Balance

Risk stratification and principles of addiction medicine applied to opioid prescribing

Widespread Use

Opiophobia must go

Opioid Prescribing: In and Out of the Box



Pain Syndrome in Which Opioid Use Controversial

Dose >180 mg MSO_4 equivalents daily

Active Psych or Substance Abuse

Contact With Nonmedical Users

Younger Age

Management of Risk Is a "Package Deal"

- Screening & risk stratification
- Use of PMP data
- Compliance monitoring
  - Urine screening
  - Pill/patch counts
- Education **re** drug storage & sharing
- Psychotherapy & highly "structured" approaches
- Abuse-deterrent formulations

The Four "A's" of Pain Treatment Outcomes

- **A**nalgesia (pain relief)
- **A**ctivities of Daily Living (psychosocial functioning)
- **A**dverse effects (side effects)
- **A**berrant drug-taking (addiction-related outcomes)

Passik SD, Weinreb HJ. *Adv Ther*. 2000;17:70-80.

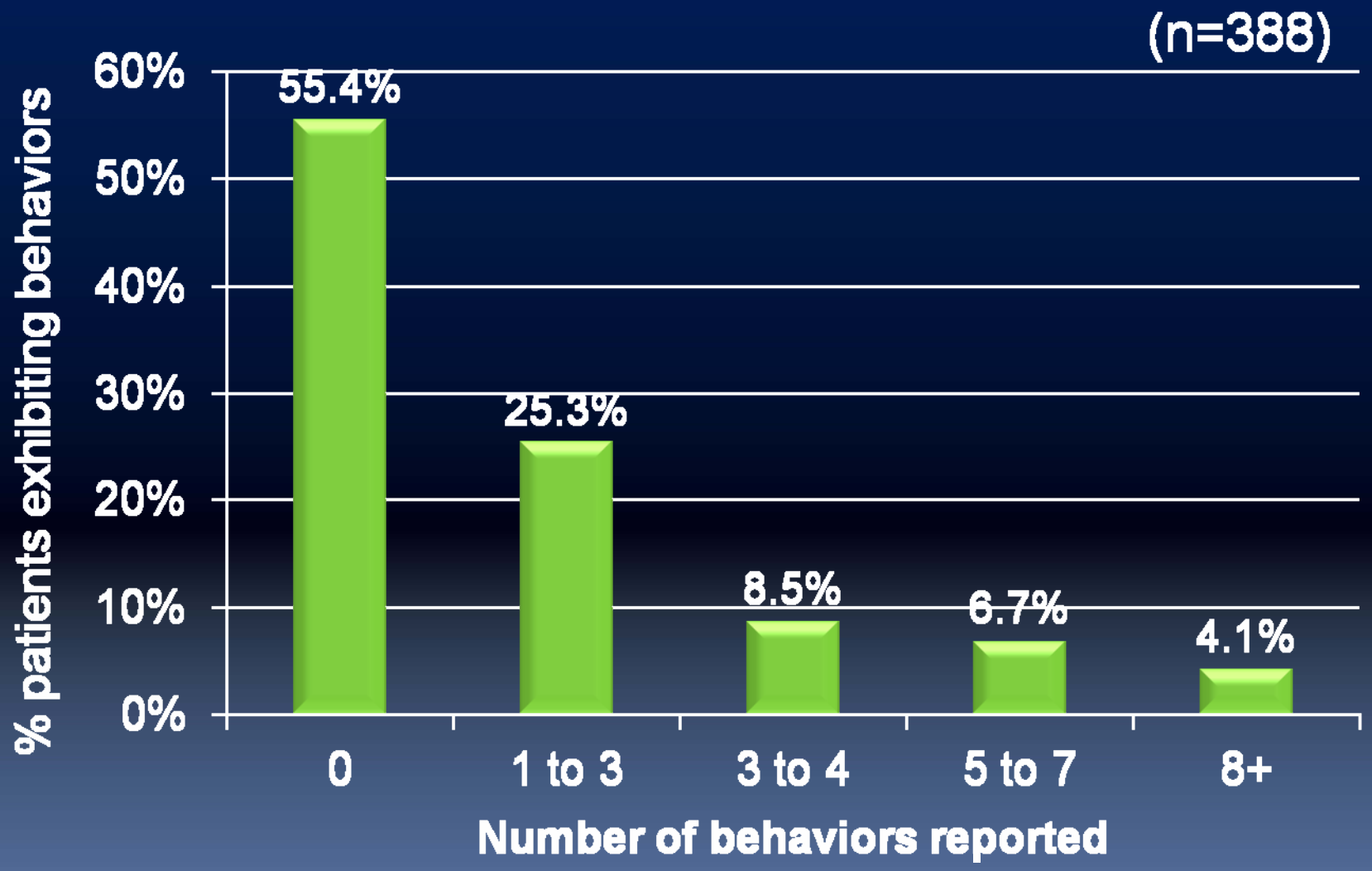
My Dog on Opioids

Aberrant Drug-Taking Behaviors (ADTBs): The Model

- Probably more predictive
  - Selling Rx drugs
  - Prescription forgery
  - Stealing or borrowing another patient's drugs
  - Injecting oral formulation
  - Obtaining Rx drugs from non-medical sources
  - Concurrent abuse of related illicit drugs
  - Multiple unsanctioned dose escalations
  - Recurrent prescription losses
- Probably less predictive
  - 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 X
  - Unapproved use of the drug to treat another symptom
  - Reporting psychic effects not intended by the clinician

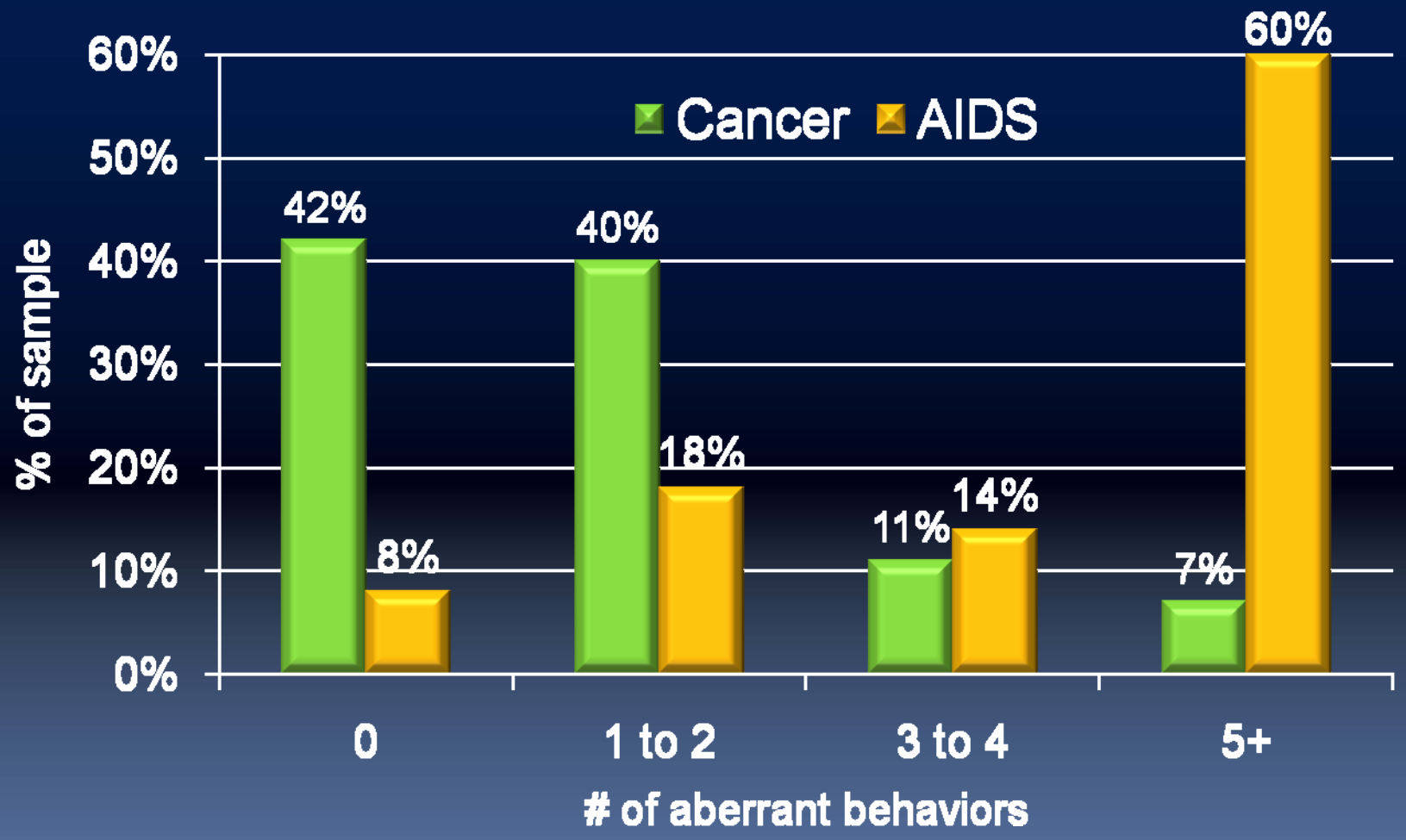
Passik SD, Portenoy RK. *Principles & Practice of Supportive Oncology*. Lippincott-Raven, NY: 1998;513-30.

Aberrant Behaviors



Passik SD, et al. *J Opioid Manage.* 2005;1:257-66.

Aberrant Behaviors in Cancer & AIDS



Passik SD, et al. *Clin J Pain*. 2006;22:173-81.

AIDS Patients & Aberrant Behaviors

	Adequate analgesia (n=49)	Inadequate analgesia (n=24)
Total # aberrant behaviors	305 (6.2)	152 (6.3)
Aberrant behaviors "probably LESS indicative of addiction"	239 (78%)	116 (74%)
Aberrant behaviors "probably MORE predictive of addiction"	66 (22%)	40 (26%)

Differential Diagnosis: Aberrant Drug-Taking Attitudes & Behavior

- Addiction
  - *Compton*
  - *Fleming*
- Pseudo-addiction
  - *Elander*
- Other psychiatric diagnosis
  - Organic mental syndrome
  - Personality disorder
  - Chemical coping
  - Depression/anxiety/situational stressors
    - *Butler*
- Criminal intent
  - *Katz*
  - *Jung & Reidenberg*

Surprise Urine Drug Test

UDT Results	Issues		
	Yes (%)	No (%)	Total (%)
+	10 (8)	26 (21)	36 (29)
–	17 (14)	69 (57)	86 (76)
Total	27 (22)	95 (78)	122

A total of 53 (43%) had a “problem” so identified

Katz NP, et al. *Anesth Analg*. 2003;97:1097-102.

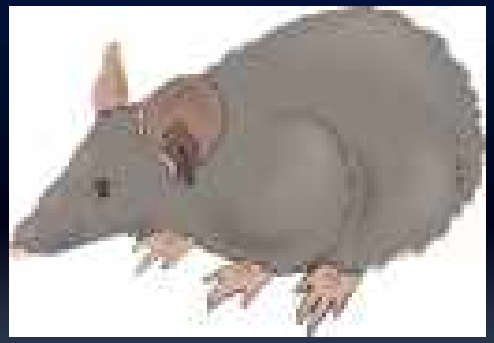
New Technology for Urine Screening

Assessment of Addiction Risk

- Measures for screening for addiction risk
  - STAR/SISAP
  - CAGE AIDD
  - Opioid Risk Tool (Emerging Solutions in Pain)
  - SOAPP (see painedu.org)
- Psychiatric interview assessment of risk
  - Chemical
  - Psychiatric
  - Social/Familial
  - Genetic
  - Spiritual

What Kind of a Rat am I?

Fisher 344	Abstinence	drug rejecting
Lewis	Polysubstance Abuse	drug seeking
Sprague-Dawley	Average	drug neutral



With Permission: Lynn Webster M.D., Lifetree Clinical Research and Pain Clinic Salt Lake City, Utah.

Screening Instruments

- Several clinical tools are available that estimate risk of noncompliant opioid use[1-3]
- Results determine how closely a patient should be monitored during opioid therapy[3]
  - *Scores implying a high risk of abuse are not reasons to deny pain relief*[3]

[1]Webster LR, Webster RM. *Pain Med.* 2005;6:432-42. [2]Coambs RB, et al. *Pain Res Manage.* 1996;1:155-62. [3]Butler SF, et al. *Pain*. 2004;112:65-75.

Opioid Risk Tool (ORT)

Mark each box that applies	Female	Male
1. Family history of substance abuse		
Alcohol	❑ 1	❑ 3
Illegal drugs	❑ 2	❑ 3
Prescription drugs	❑ 4	❑ 4
2. Personal history of substance abuse		
Alcohol	❑ 3	❑ 3
Illegal drugs	❑ 4	❑ 4
Prescription drugs	❑ 5	❑ 5
3. Age (mark box if between 14-45 years)	❑ 1	❑ 1
4. History of preadolescent sexual abuse	❑ 3	❑ 0
5. Psychologic disease		
ADD, OCD, bipolar, schizophrenia	❑ 2	❑ 2
Depression	❑ 1	❑ 1
Scoring totals:		

Administration

- On initial visit
- Prior to opioid therapy

Scoring (risk)

- 0-3: low (6%)
- 4-7: moderate (28%)
- ≥8: high (>90%)

Webster LR, Webster RM. *Pain Med.* 2005;6:432-42.

Screening Instrument for Substance Abuse Potential (SISAP)

Question	Caution
How many alcoholic drinks/day?	Men: ≥5 drinks/day Women: ≥4 drinks/day
How many alcoholic drinks/week?	Men: ≥17 drinks/week Women: ≥13 drinks/week
Use of marijuana/hashish in last year?	Admission of recent use
Have you ever smoked cigarettes?	Persons who are younger than 40 years & smoke
What is your age?	

Coambs RB, et al. *Pain Res Manage.* 1996;1:155-62.

Screener & Opioid Assessment for Patients in Pain (SOAPP)

- 14-item, self-administered form, capturing the primary determinants of ADRB
  - Validated over 6-month period in 175 chronic pain patients
  - Adequate sensitivity & selectivity
  - May not be representative of all patient groups
- Score of ≥7 identifies 91% of patients who are high risk

Butler SF, et al. *Pain*. 2004;112:65-75

Opioid Renewal Clinic

Procedure

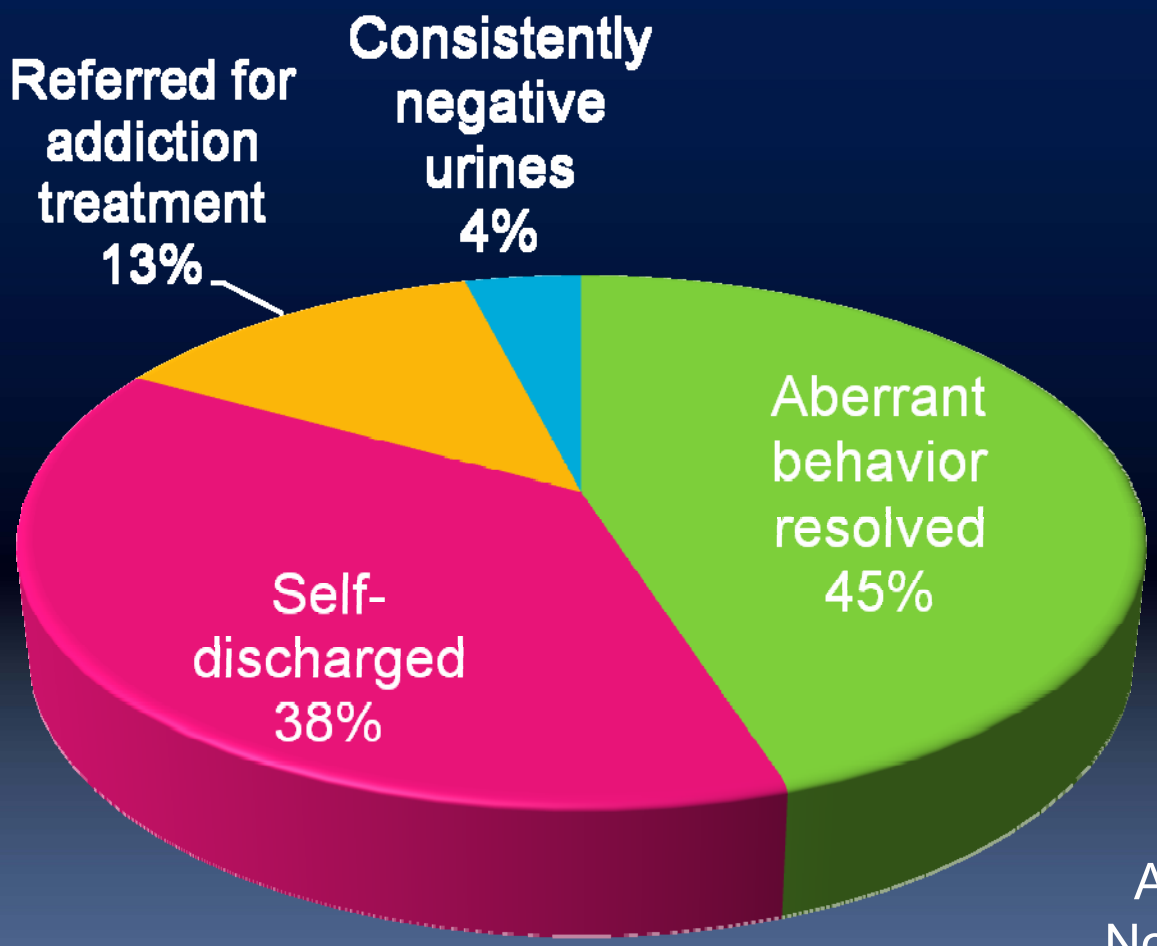
- Consult from PCP
- Elligibilty
  - Workup & pain dx
  - Opioid Treatment Agreement
  - Baseline urine drug test
- PCP CONTINUES TO BE RESPONSIBLE TO PRESCRIBE OPIOIDS

Strategy

- Opioid Treatment Agreement
  - Second Chance Agreement
- Frequent visits
- Prescribing opioids on short-term basis
  - ie, weekly or bi-weekly
- Random UDT
- Pill counts
- Co-management with addiction services

Gallagher et al. *Pain Med*. 2007.

Aberrant-Behavior Categories (n=171)



Aberrant behavior = 171
No aberrant behavior =164

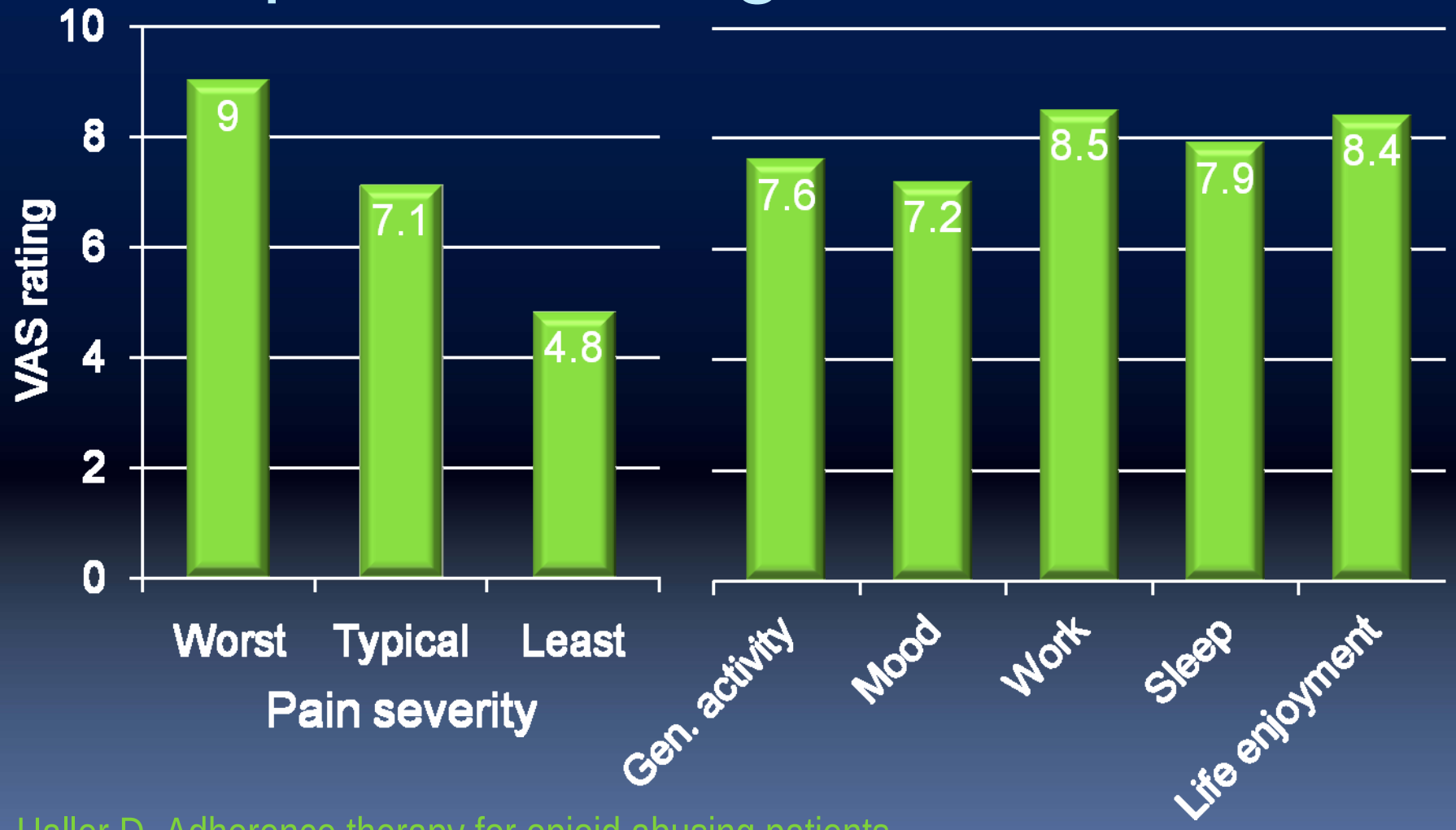
Gallagher et al. *Pain Med*. 2007.

NIDA Study: Adherence Therapy for Opioid Abusing Pain Patients

- 40 pain patients at 2 sites in Virginia & New York
  - Evidence of opioid efficacy for diagnosis
  - >6 mo duration, constant, moderate-severe intensity (VAS >7 despite daily opioids)
- Substance abuse co-morbidity
  - Opioid abuse or dependence, >2 on "problems with pain meds", no current substance dependence, & lifetime dependence or current abuse permissible
- Psychiatric co-morbidity
  - No unstable major psychiatric disorders, current suicidal/ homicidal ideation, or medication dose considerations
- Medical co-morbidity
  - No unstable/severe medical conditions or planned surgery within study period; no meds that interact with methadone

Haller D. Adherence therapy for opioid abusing patients.
"PROJECT PAIN." NIDA (Grant #R01DA1369). Presented at 2006 CPDD Conference.

NIDA Study: Adherence Therapy for Opioid Abusing Pain Patients



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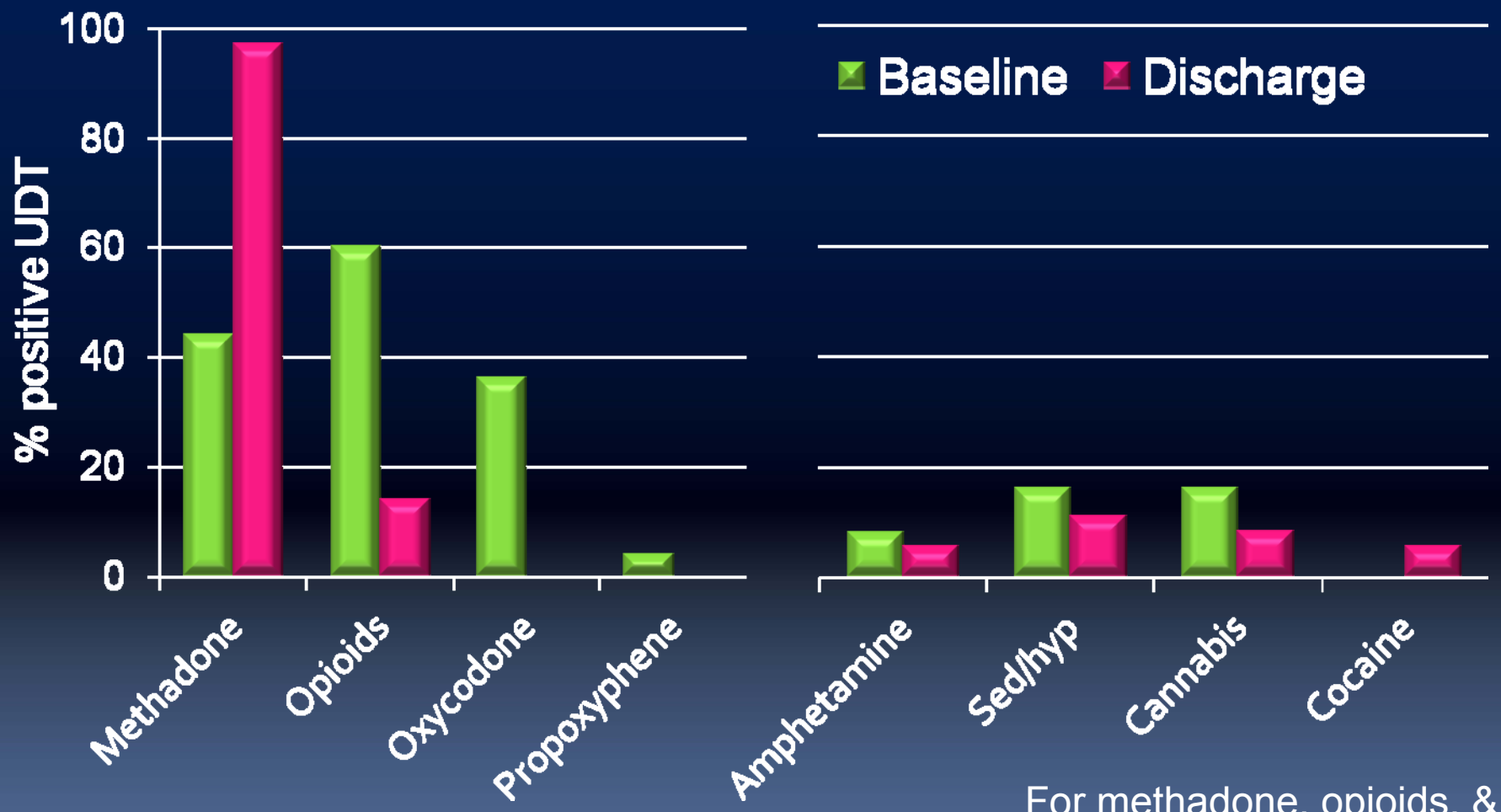
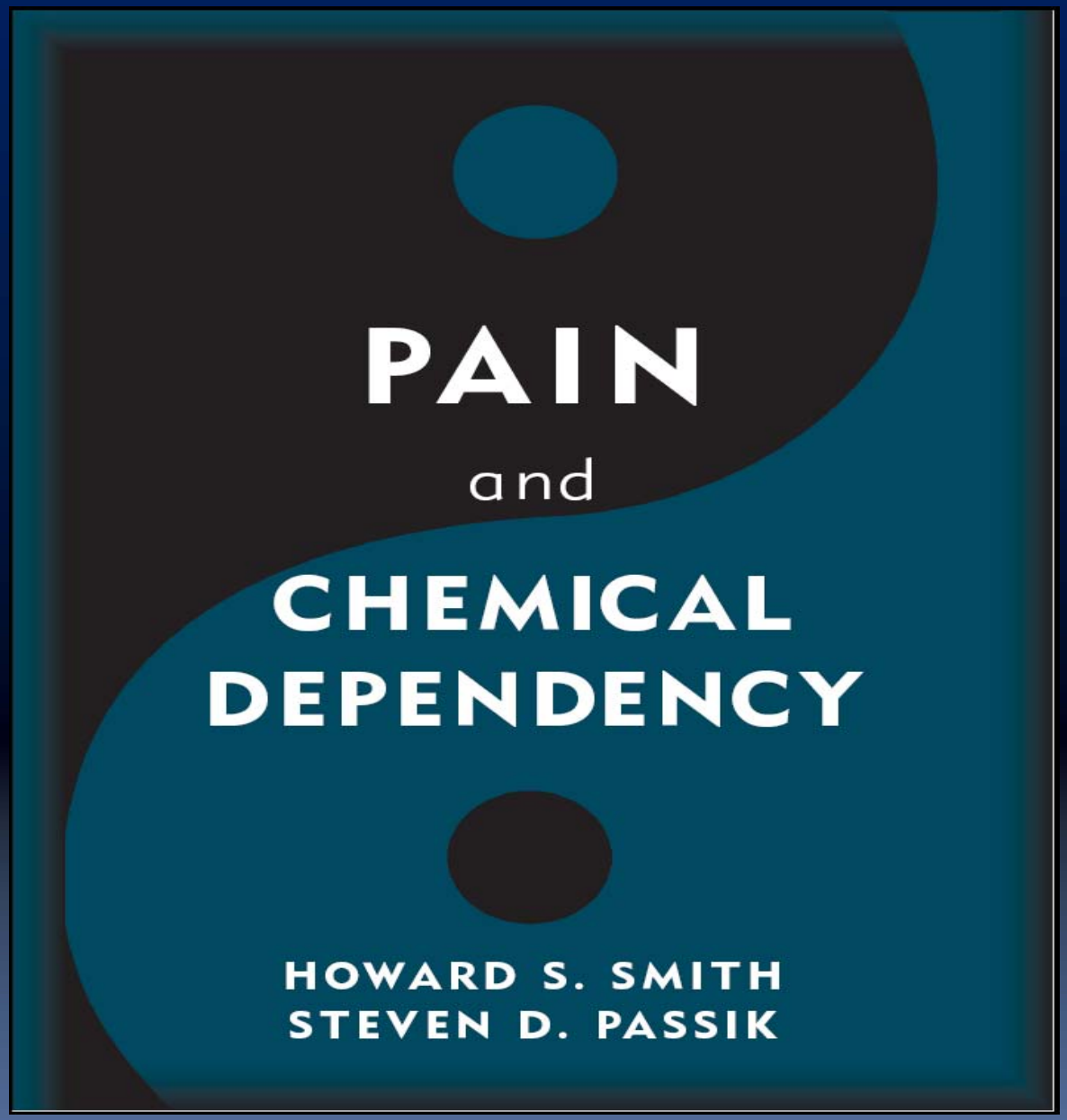
Trends in Opioid & Non-opioid Use



For methadone, opioids, & oxycodone $P < .01$

Haller D. Adherence therapy for opioid abusing patients. "PROJECT PAIN." NIDA (Grant #R01DA1369). Presented at 2006 CPDD Conference.


PAIN
and
CHEMICAL
DEPENDENCY
HOWARD S. SMITH
STEVEN D. PASSIK

Summary

- Empirical data has been accruing on aberrant drug-taking behaviors (ADTBs)
- These studies are beginning to tell us:
  - ADTBs are common
  - Frequency of ADTBs relates to addiction risk in the sample
  - ADTBs can be predicted
  - Not impacted by adequacy of pain control in the dual diagnosis group of patients(?)
  - Can be managed with highly structured approaches