Dependence vs. Addiction: Different Conditions, Different Approaches

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An opioid misuse, addiction and accidental overdose epidemic.

- It is estimated that there are more than 10,000 patients in Maine whose current opioid regime exceed 200 MME’s per day.
- All of these patients have developed a tolerance to opioids such that in their absence, a withdrawal syndrome will develop.
- As a result, all of these patients meet criteria for Opioid Dependence (tolerance and withdrawal).
- The CDC has identified strengths and limitations with opioid prescribing for chronic non-cancer pain and is promoting standard dosing guidelines that do not generally exceed 90 MME’s per day.

Prevalence and Implications for Care

• Risk for accidental death within 18 months of analgesic initiation is found to be as high as 1 in 32 patients when taking 200 MME’s per day.

• Prevalence of opioid addiction among chronic non-cancer pain patient populations: Standardized assessment interviews found among 705 patients, 35% met both DSM IV and V criteria for a substance use disorder.

• Responding to opioid dependence and addiction through systems for screening, assessment, treatment/referral infuses patient and practice protective factors reducing incidence of accidental overdose.


You’ve determined that your patient is physiologically dependent on opioids....

WHAT DO YOU DO?
Dependence is **not** addiction, but it is a **risk factor** for addiction.

Withdrawal

- Dependence implies that withdrawal symptoms will occur in the absence of the substance.
- The experience of withdrawal is traumatic.
- The traumatic nature of withdrawal (experienced or anticipated) leads to an inevitable, universal desire to avoid it.

Aversive Experience vs Aberrant Behavior

- The experience of withdrawal and the aversion to it do not distinguish physiological dependence from addiction, but the **length that one goes to avoid withdrawal** DO begin to differentiate the two.

- Twitching, tremors, or shaking
- Joint and bone aches
- Bad chills or sweating
- Anxious or irritable
- Goose pimples

- Very restless, can’t sit still
- Heavy yawning
- Enlarged pupils
- Runny nose, tears in eyes
- Stomach cramps, nausea, vomiting, or diarrhea
Back to the original question….What to do with your patient experiencing physiological opioid dependence?

**Actively** manage their pain conditions while working to prevent transition from dependence to addiction.

Patient Education on Individualized Risk

- Provide **education** about the risk of addiction, the difference between dependence and addiction, and the factors that increase risk of converting from dependence to addiction (e.g. ACE scores).


Continual Assessment: Acute vs Chronic Pain Management

• Regularly **re-assess the pain condition** driving the need for opiates as well as related **functionality**.

• Regularly evaluate the **duration** of treatment with opioids. Data supports opioid use for acute pain and does NOT support it for chronic pain, i.e. opioids are known to hurt and not necessarily to help in the long run.

Natural Supports and Collateral Contact

• Engage **patient’s family** and **supports** in the process.

• The patient’s subjective report of their functionality related to their pain and opioid use should be corroborated by **collateral information** from trusted others whenever possible.

Regularly assess the ‘5 A’s’

- Analgesia
- Activity
- Adverse Effects
- Aberrant behavior
- Affect

Collaboration with Mental Health Clinicians

• Address patient’s beliefs and feelings about pain that may impact opiate usage.
• Introduce the interrelatedness of mental health and pain and the utility of mental health supports BEFORE questions of aberrant use arise.
  – Identify pain/living with pain (vs substance misuse) as the challenge to be confronted
  – Decrease stigma (see the ‘shrink’ when you’re ‘bad’)
• Identify and treat underlying mental illnesses, such as depression, which may complicate the picture of opioid use
  – e.g. patient may feel emotional relief from opioid use as well as relief of somatic pain

Multidisciplinary Pain Management

- **Collaborate** with pain management specialists, physical therapists and others to introduce as many effective non-opioid management strategies into the patient’s care.

- This can serve to empower the patient **(active vs passive pain management)**. It may also decrease overall dosage thereby decreasing risk of overdose AND risk of transition from dependence to addiction.

Reducing risk in current and prospective patient populations

• Routine screening and assessment of patients for risk of substance use disorders helps assure the lowest amount of risk for patients prior to the initiation of opioid prescribing for chronic, non-cancer pain.

• When patients enter a practice with established chronic opioid treatment, retrospective screening and assessment is recommended to begin engaging patients in the safest plans.

• Regular screening for changes in risk (as well as changes in the condition being treated) facilitate ongoing safety.

Screening for Substance Use Disorders

• Order Sets: UDS, PMP
  ✓ DSM 5, Opioid Risk Tool, Ten Factor Office-Based Criteria, Treatment Needs Questionnaire
• Intake
  ✓ Informed Consent/Universal Precautions
  ✓ Release of Information
• Patient / Significant others’ information
• Diversion
  ✓ UDS Schedule, Pill Count Schedule

https://www.mainequalitycounts.org/page/2-1401/controlled-medication-playbook
Patient Assessment and Evaluation for Substance Use Disorders

- Patients requesting or are identified by the practice
- All drugs of use (long acting verses short acting opioids, other drugs paying attention to alcohol, benzodiazepines)
  - Route of admin
  - Overdoses
  - Past treatment, pain management records
- Psychiatric history
  - ADHD, PTSD, bipolar disorder, hospitalizations, SI/SA
- Conduct a history and physical (or review if previously completed)
  - Birth control
  - PCP involvement (if in specialty setting)
  - Laboratory tests: LFTs, HIV, hepatitis, CMP, CBC, HCG if female pre-menopausal, UDS, others if indicated, i.e., TB, sexually transmitted diseases, etc. ETOH bio-markers as indicated.
DSM V Substance Use Disorder Criteria:
Opioid Addiction-Mild, Moderate, Severe

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
DSM V Criteria Continued

7. Important social, occupational, or recreational activities are given up or reduced because opioid use.

8. Recurrent opioid use in situations in which it is physically hazardous.

9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

10. Tolerance, as defined by either of the following: a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect. b. A markedly diminished effect with continued use of the same amount of an opioid.

11. Withdrawal, as manifested by either of the following: a. The characteristic opioid withdrawal syndrome b. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

Specify current severity: 305.50 (F11.10) Mild: Presence of 2–3 symptoms. 304.00 (F11.20) Moderate: Presence of 4–5 symptoms. 304.00 (F11.20) Severe: Presence of 6 or more symptoms.
Diagnostic Specifiers

• In early remission: none of the criteria for opioid use disorder have been met for at least 3 months but for less than 12
• In sustained remission: none of the criteria for opioid use disorder have been met at any time during a period of 12 months or
• On maintenance therapy: if the individual is taking a prescribed agonist medication such as methadone or buprenorphine and none of the criteria for opioid use disorder have been met for that class of medication, also applies to partial agonist, an agonist/antagonist, or a full antagonist such as oral naltrexone or depot naltrexone.
• In a controlled environment: used if the individual is in an environment where access to opioids is restricted.
When you’ve diagnosed a patient with Opioid Use Disorder….

• Educate the patient about the impact of addiction on overall health, and functioning.
• Convey the Risk: Discuss the prognosis of untreated and treated opioid addiction.
• Stay present and non-pejorative: Assure, with compassion, that you will stay engaged with them regarding their pain, concern about withdrawal, and the relationship of these challenges to their new diagnosis.
• Tailor your approach to treatment and recovery based on the strength of a patient’s conviction that they have a substance use disorder and the extent to which they believe they can be successful in addressing it.

https://www.mainequalitycounts.org/page/2-1401/controlled-medication-playbook
Brief Intervention: FLO (Feedback, Listen, Options explored)

Feedback
- Setting the stage
  - Tell screen/assess results
- Listen & understand
  - Explore pros & cons
  - Explain importance
  - Assess readiness to change
- Discuss change options
- Options explored
- Follow up

Quality Counts
Specialty addiction treatment: Clinical setting? Intensity of Need and Lethality of Consequences

• The severity modifiers associated with patients’ opioid addiction guide next steps in building a menu of treatment options and directing patients towards the most appropriate clinical environment for care.
• Practices may find that mild and moderate severity of addiction along with straightforward pain regimens can be stabilized in their current setting.
• Primary care practices may find that patients with moderate and severe addiction along with complicated pain regimens require referral to specialty addiction treatment.
• Medication Assisted Treatment is the standard of care for opioid addiction and can reduce accidental overdose by 50%.

# Specialty Treatment or Primary Care

## Treatment Needs Questionnaire

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you employed?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Do you have 5 or more close friends or family members who do not use alcohol or drugs?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Do you have a partner that uses drugs or alcohol?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Is your housing stable?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Do you have any legal issues (e.g., charges pending, probation, parole, etc)?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Have you ever been charged (not necessarily convicted) with drug dealing?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Are you currently on probation?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Do you have any psychiatric problems (e.g., major depression, bipolar, severe anxiety, PTSD, schizophrenia, personality subtype of antisocial, borderline, or sociopathy)?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Do you have a chronic pain issue that needs treatment?</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Do you have access to reliable transportation?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Do you have a reliable phone number?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>If you have ever been on medication-assisted treatment (e.g., methadone, buprenorphine) before, were you successful?</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Do you have a problem with alcohol, have you ever been told that you have a problem with alcohol, or have you ever gotten a DWI/DUI?</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Do you even use cocaine, even occasionally?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Do you ever use benzodiazepines, even occasionally?</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Are you motivated for treatment?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Are you currently going to any counseling, AA, or NA?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Do you have any significant medical problems (e.g., hepatitis, HIV, diabetes)?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Have you ever used a drug intravenously (IV)?</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Are you a parent of a child under age 18? If so, does your child live with you?</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Did you receive a high school diploma (e.g., did you complete &gt;12 years of education)?</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Calculate total: __________

Total possible points is 26.

**Score: 0-10**  Consider as candidate for lower-intensity/office-based treatment, with movement toward more intensive treatment if patient destabilizes.

**Score: 11-26**  Consider as candidate for higher-intensity/clinic-based treatment, followed by a potential reduction in intensity contingent upon documented treatment success.
Recovery from Addiction

Goals of recovery from a substance use disorder:

“A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”

http://blog.samhsa.gov/2012/03/23/definition-of-recovery-updated/#.V_knXvkrKCg