



DRUG ENFORCEMENT ADMINISTRATION

MUSEUM  
& VISITORS CENTER

DEA Museum  
Fall 2015 Lecture Series

# DEA Museum Lecture Series

Please join the DEA Museum for the final lecture of the Fall 2015 Lecture Series

## OPIATE MISUSE, OVERDOSE, & ADDICTION – CAUSES & SOLUTIONS

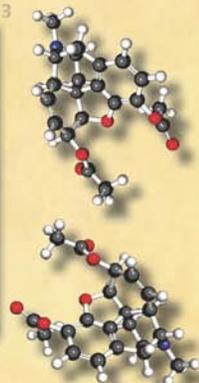
Tuesday, November 17, 11:00 AM Eastern

DEA Museum HQ Auditorium

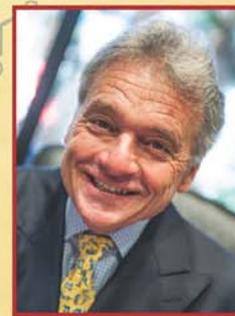
with LIVE webcast on [www.deamuseum.org](http://www.deamuseum.org)



Dr. William Jacobs  
Chief of Addiction Medicine  
Medical College of Georgia



Dr. Theodore Cicero  
Professor of Psychiatry  
Washington University



Dr. Mark Gold  
Chairman of the Scientific  
Advisory Board  
RiverMend Health

Opiate addiction along with pain management combined with substance use disorders is a growing concern. Please join us as we learn from two very distinguished scientists about opiates. Dr. Theodore J. Cicero, Professor of Psychiatry at Washington University in St. Louis will speak on *The Opiate Overdose & Addiction Epidemic*, and Dr. William S. Jacobs, Chief of Addiction Medicine at the Medical College of Georgia & Medical Director of the Bluff Plantation will speak on *The Role of Pain, Pain Medicine, and Physicians in Treatment of Pain and Substance Use Disorders*. The presentation will be moderated by Dr. Mark Gold, best known for his work on the brain systems underlying the effects of drugs; distinguished alumnus of Washington University, University of Florida, and Yale University; Chairman of the Scientific Advisory Boards for RiverMend Health; and Director of Research and Prevention for the DEA Educational Foundation.



Sign language interpretation will be provided.

For more information, please contact the DEA Museum Education Department at 202-307-3463.

# Opiate Misuse, Overdose, & Addiction – Causes & Solutions

- **DEA Museum Lecture Series**
- **Tuesday, November 17, 11:00 AM Eastern**
- **DEA Museum HQ Auditorium ---with LIVE webcast on *www.deamuseum.org***
  
- **Dr. Theodore Cicero**
- **Professor of Psychiatry**
- **Washington University**
  
- **William Jacobs , M.D.**
- **Anesthesiologist, Pain Medicine & Addiction Medicine**
- **Chief of Addiction Medicine**
- **Medical College of Georgia**

# Theodore J. Cicero, PhD



- John P. Feighner Professor of Psychiatry, Washington University in St. Louis School of Medicine.
- Faculty member at Washington University in St. Louis for 45 years.
- Author of over 200+ scientific articles in field of substance abuse research.
- Previous experience
  - Neurological substrates of dependence and abuse of drugs (opiates and alcohol) in animal models.
  - Pioneer in epidemiological surveillance systems for prescription opioids, including abuse deterrent formulations.
  - Following the impact of prescription opioids on heroin use and its shift into newer populations.
  - Qualitative research on the demand that drives abuse.

Shifting Patterns of Prescription Opioid and Heroin Abuse in the United States  
N Engl J Med 2015; 373:1789-1790 [October 29, 2015](#) DOI: 10.1056/NEJMc1505541

- These findings suggest that as prescription opioid use has waned, concurrent heroin abuse has increased, with important, distinct regional variations. The factors contributing to these evolving changes are not well established. However, in our exploratory qualitative online survey of a subgroup of 267 patients, among the 129 respondents who reported abusing prescription opioids prior to heroin use, 73.0% (92 of 126 respondents) primarily cited practical factors, such as accessibility and cost, when explaining their transition to heroin. Three of the 129 respondents did not provide an explanation for their transition to heroin
- Theodore J. Cicero, Ph.D.  
Matthew S. Ellis, M.P.E.  
Jessie Harney, M.S.  
Washington University, St. Louis, MO  
[cicerot@wustl.edu](mailto:cicerot@wustl.edu)

# William S. Jacobs, MD



- Medical Director, Bluff Plantation
- Associate Professor and Chief Addiction Medicine-Medical College of Georgia
- Triple Board Certified-Board certified in Anesthesiology, Pain Medicine and Addiction Medicine
- National forensic expert in iatrogenic addiction, smoking-nicotine addiction and substance abuse
- Author of Detoxification and Practice Guidelines, Principle Investigator (e.g. Pivotal Clinical Trials in Smoking Cessation), and peer reviewed, scientific papers on pain and addictions
- Previously Experience
  - Director of Interventional Pain & Associate Professor, University of Florida College of Medicine
  - Founding Faculty, Division of Addiction Medicine& University of Florida Recovery Center
  - Consultation to the DEA on safe prescribing of narcotics
  - Medical Director, Wekiva Springs
  - Medical Director, Gateway Community Services
  - Medical Director, Stewart Marchman
  - Medical Director, Lakeview Hospital
  - Owner and Founder NexStep Integrated Pain Care

# Train doctors to recognize addiction

Atlanta Journal Constitution -Friday, Oct. 9, 2015

By William S. Jacobs

- Less than 10 percent of addicts receive treatment. The ones who do are often in crisis mode, where the illness has gotten so severe they realize, or someone in their life realizes, that they need immediate intervention. With nearly 8 percent of Georgians over the age of 12 suffering from a substance abuse disorder, we must do a better job identifying and treating those who need help as early as possible.
- “ At the heart of the problem is a lack of addiction medicine training, especially in medical schools. Our health care providers are the first line of defense identifying addiction and providing help to those who need it, yet they have not been trained to do so.”
- “The most effective way of assuring the American public our health care system is equipped with the knowledge and skills to prevent, recognize and treat addiction is by expanding existing, specialized training programs in addiction medicine.”

# DEA Museum Format

- 20 Minute Lecture- Cicero
- 20 Minute Lecture- Jacobs
- Comments & Questions
- Open for Questions



## Transitions from Prescription Opioid Abuse to Heroin.

Theodore J. Cicero, PhD  
Washington University in St. Louis, SOM  
Department of Psychiatry



# + Conflicts of Interest/Disclosure

## ■ Research Support

- NIDA grant.
- Unrestricted research grant sponsored by Denver Health and Hospital Authority (DHHA).

# + Conflicts of Interest/Disclosure

## ■ Conflict of Interest

- Member, Scientific Advisory Board for the Researched Abuse, Diversion and Addiction Related Surveillance (RADARS®) System, which collects subscription fees from 14 pharmaceutical firms.

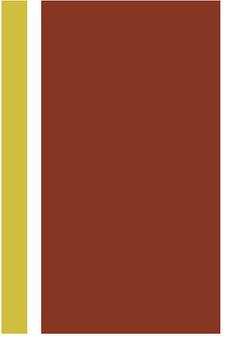


# The Prescription Opioid Epidemic

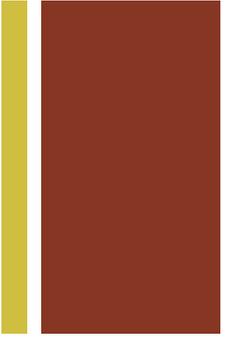


# + The Prescription Opioid Epidemic

- Two major developments of the late 1990s/early 2000s.



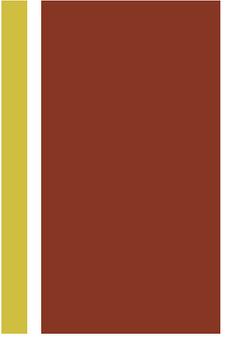
- **Joint Commission on Accreditation of Healthcare Organizations.**
  - Pain as the fifth vital sign.
  - Recommended increase use of opioids to relieve pain.



- **Release of extended-release oxycodone.**
  - Initially thought to have little abuse potential.
  - Snorting/IV injection became common.
  - Became the most widely abused prescription opioid.



Why are prescription opioids so attractive?

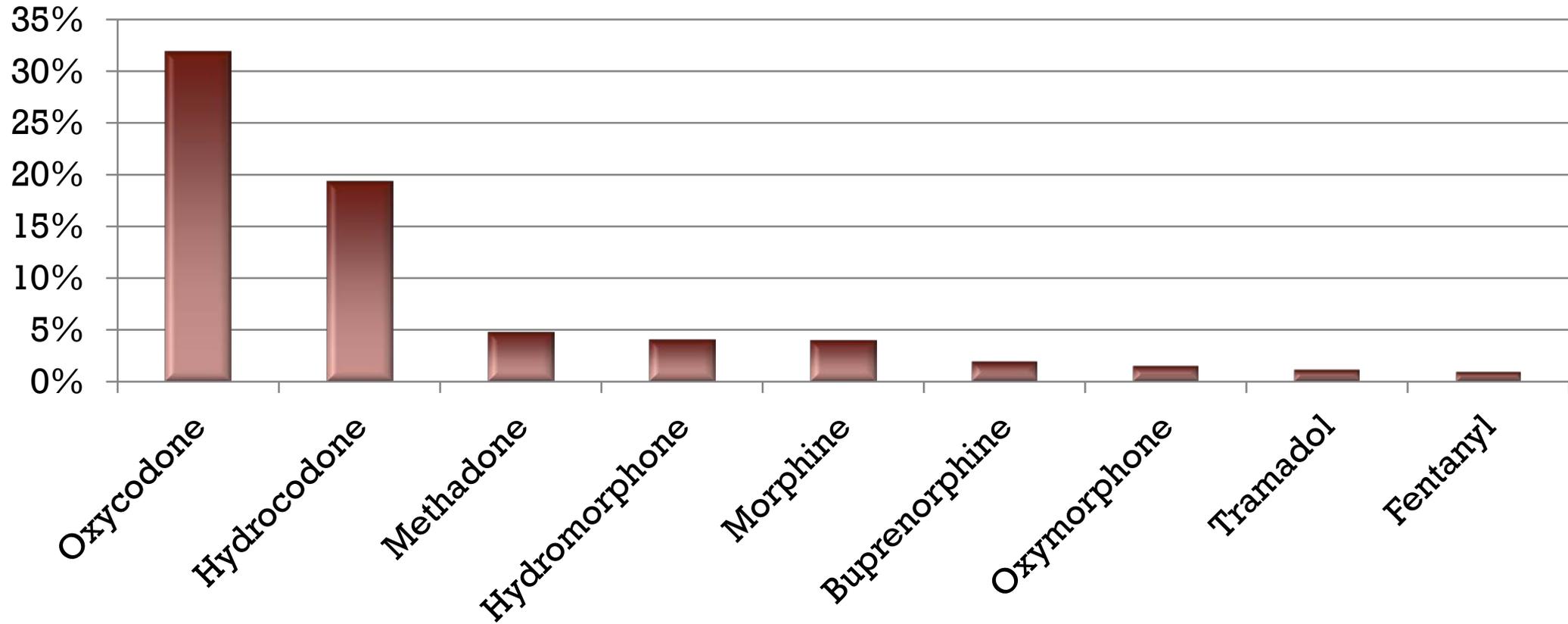


- Euphorigenic.
- They are legal, approved by FDA and prescribed by doctors.
- Seen as safer than other drugs.
- Trustworthy and predictable.
  - Dosage clearly specified on tablet/pill.
- No stigma of a “junkie”.



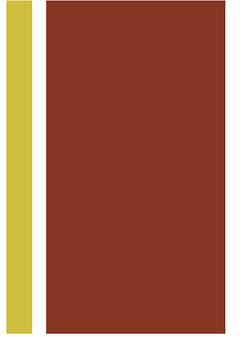
What Rx drugs are most commonly used?

# + Primary prescription opioids of abuse





Initial opioid exposure.



- Valid prescription from a physician to treat pain
  - 62.2%
- Experimental; seeking a “high”
  - 37.8%



# Representative quotes related to first use

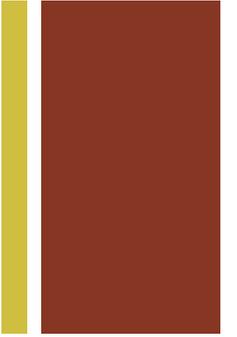


“Minutes after doing them my first time I felt like there was not a care in the world to me. Nothing and no one existed except for me and the amazing high I was feeling....”

“It was like god was petting me.”



Unanticipated “benefits” of opioids leading to  
misuse.



- 75% of the sample self-reports they used opioids to self-medicate psychiatric related issues.
- 85% of the sample self-reports the use of opioids to “escape from life”.



# Representative quotes



“I did not have any tools for coping with uncomfortable situations and the more I used opiate the more I responded/reacted to ALL situations as uncomfortable which made using drugs my go to coping skill for anything from handling emotional abuse to taking a shower.”



“They made me feel like I could talk to people and not be scared or embarrassed to walk around and just talk and be part of society.”



“Mask inside emotions/traumas, feelings of fear, self-esteem, self-pity, anger and avoiding the growing stress and responsibility of life”



“It made me feel happy and gave me the energy and want to do daily activities such as working that otherwise wouldn’t have been possible due to the debilitating depression at that time in my life.”



“The escape was from the real pain I had from the back problems, but also it allowed your mind to release and think in comfort, rather than in a stressful way...I have never been as successful or motivated or feel good as when I was on opioids.”



“It would take away the anxiety and worry I would normally feel. Smaller doses were actually more enjoyable as I could function and think I was happier.”



“Forget about shame, forget about failures/shortcomings, to get relief from personal burdens/struggles, distract self from lack of inner peace.”



“... [you’re] doing something to avoid going out and actually experiencing life.

[You’re] getting high because your too scared to go out and actually do something, too scared to put yourself out there.

It’s something familiar, friendly (at first).”

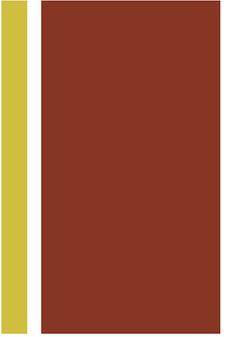


# Transitions to Heroin

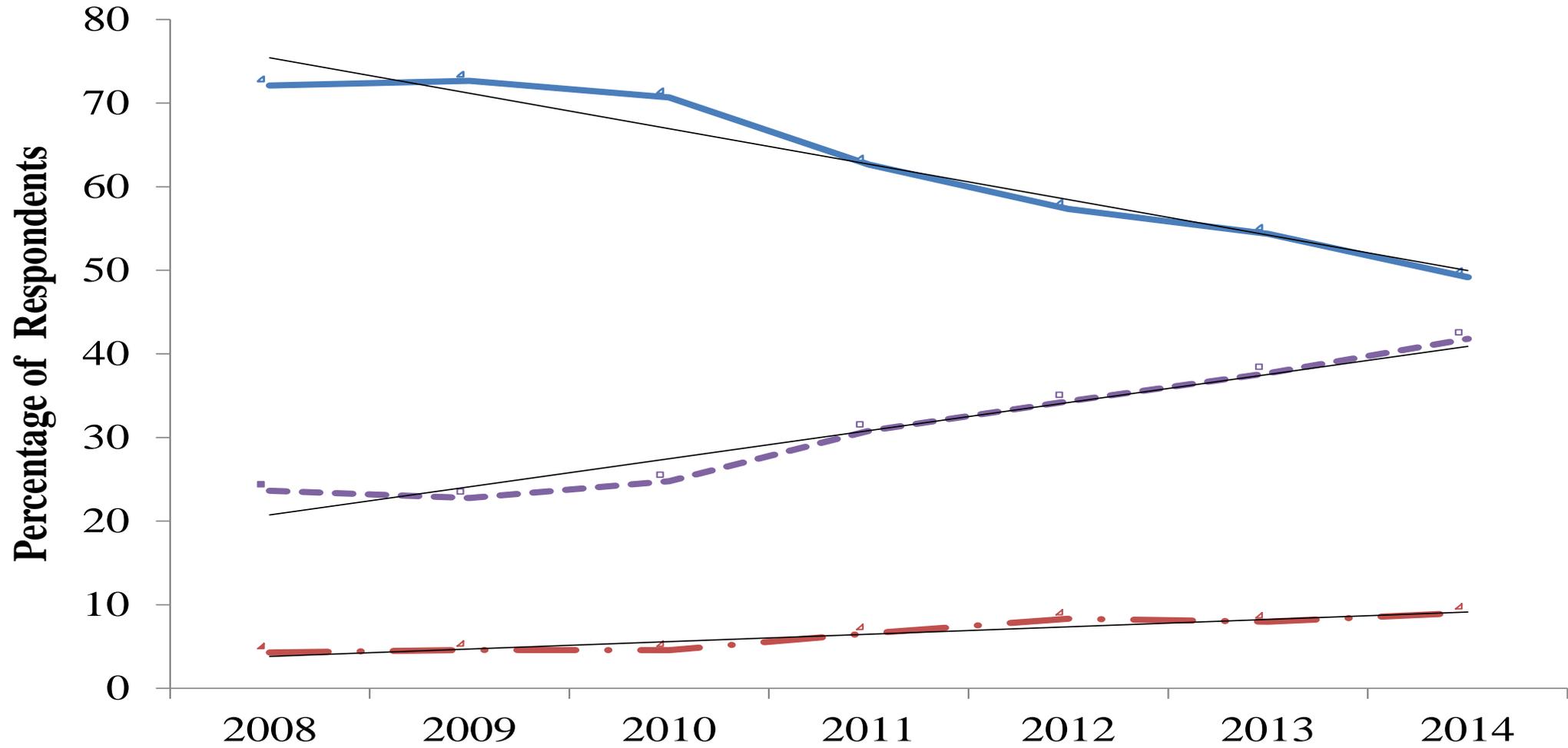


# + Rise in Heroin Use

- Two previous epidemics of heroin.
  - Post-World War II
  - Post-Vietnam War
- Both subsided; attributed due to high cost and low purity.



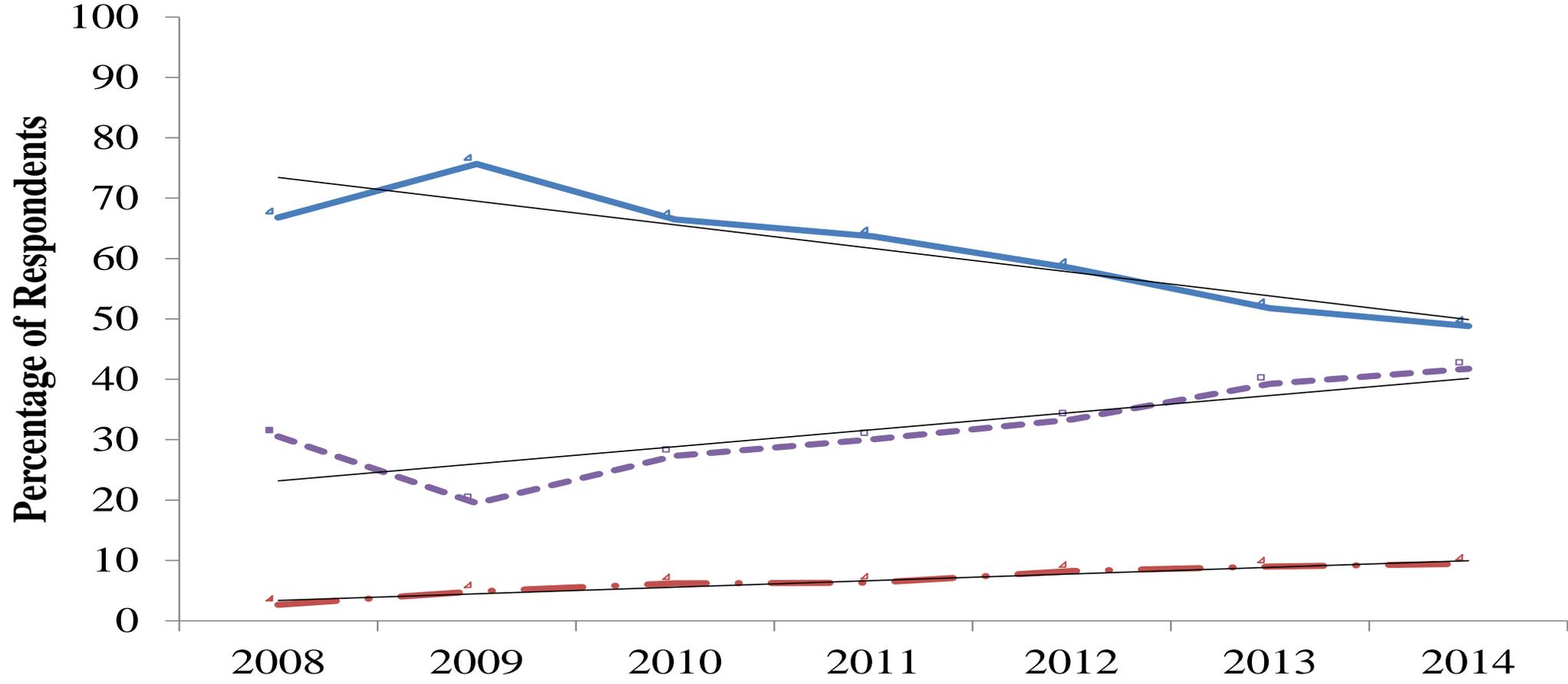
- The current epidemic went unnoticed for a long-time.
  - Backseat to prescription opioids.
  - Was not seen as important as Rx abuse because of stigma.



○ Prescription Opioids Only   ■ Heroin+Prescription Opioids   ▲ Heroin Only



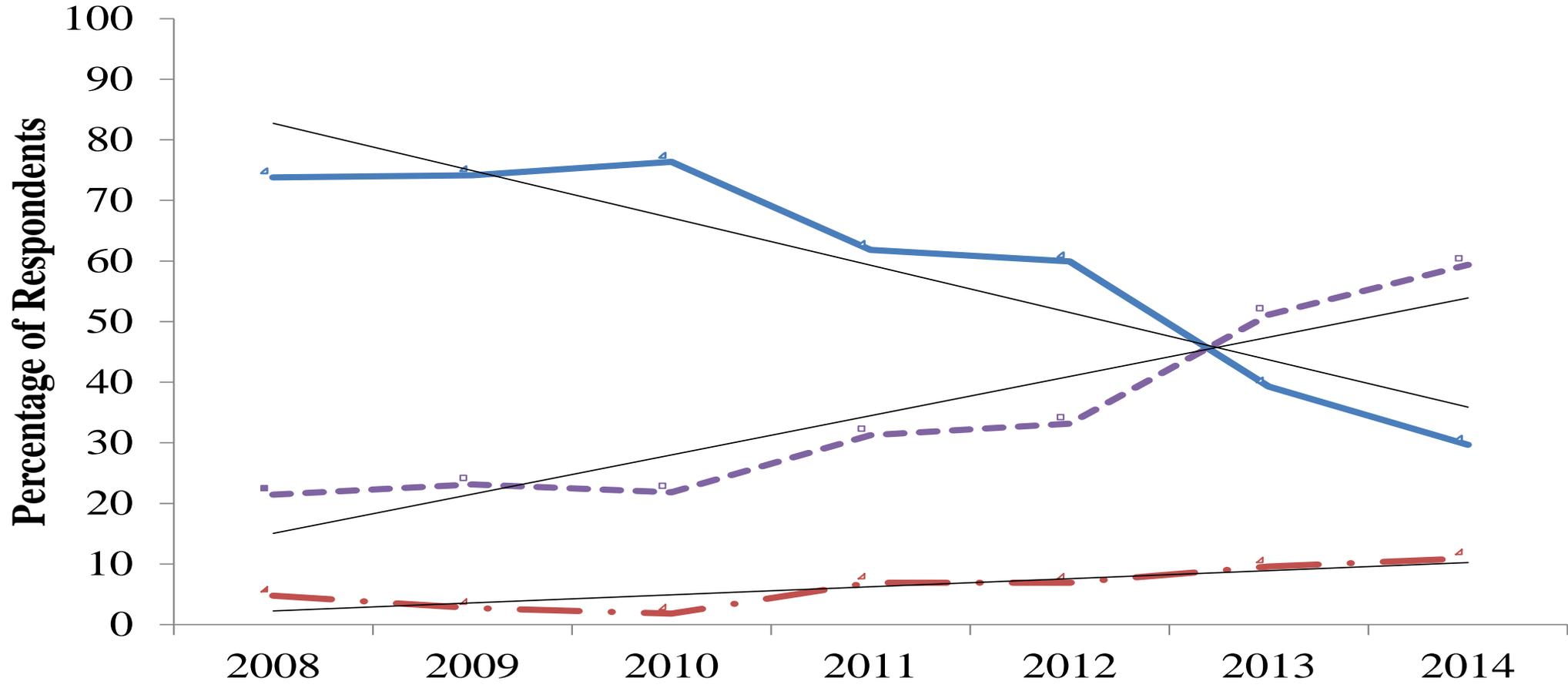
# A. Midwest



○ Prescription Opioids Only    ■ Heroin+Prescription Opioids    ▲ Heroin Only



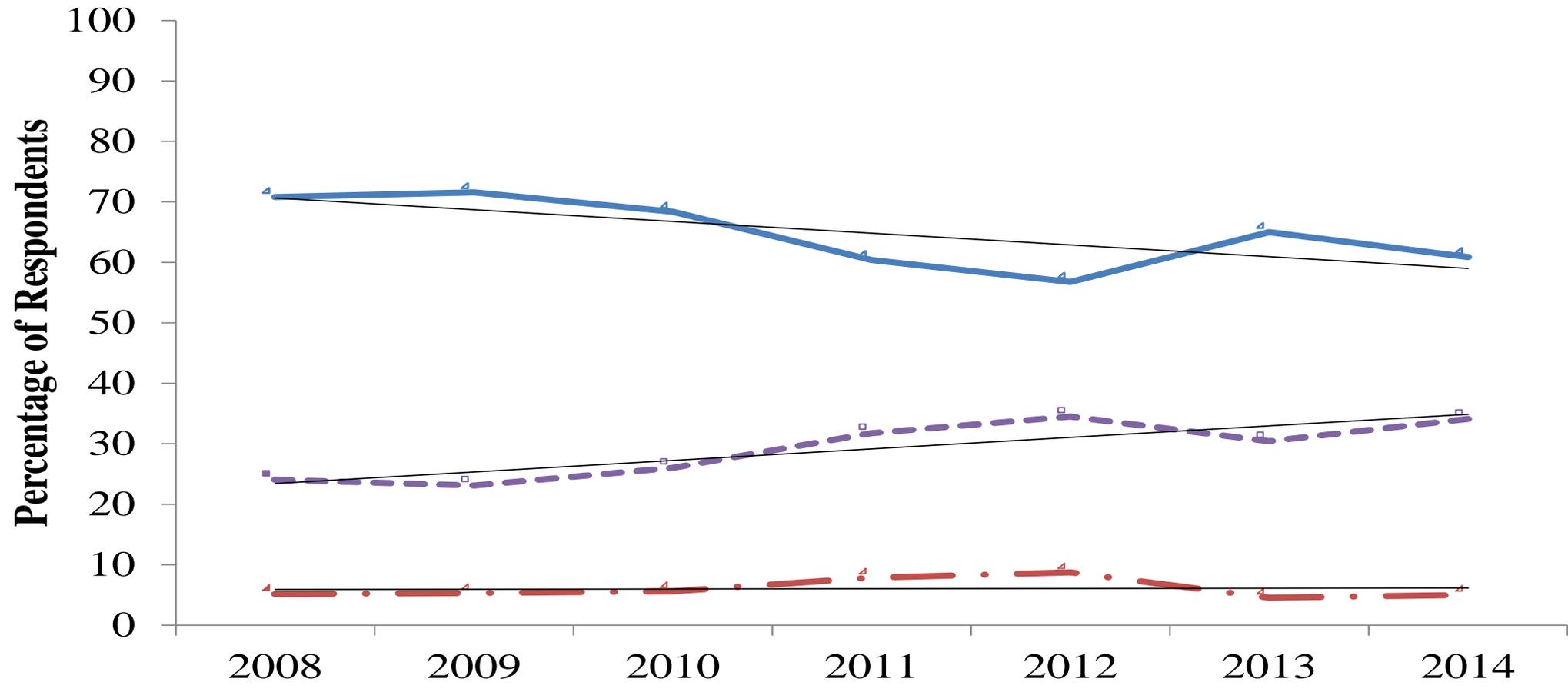
## B. Northeast



○ Prescription Opioids Only    ■ Heroin+Prescription Opioids    ▲ Heroin Only



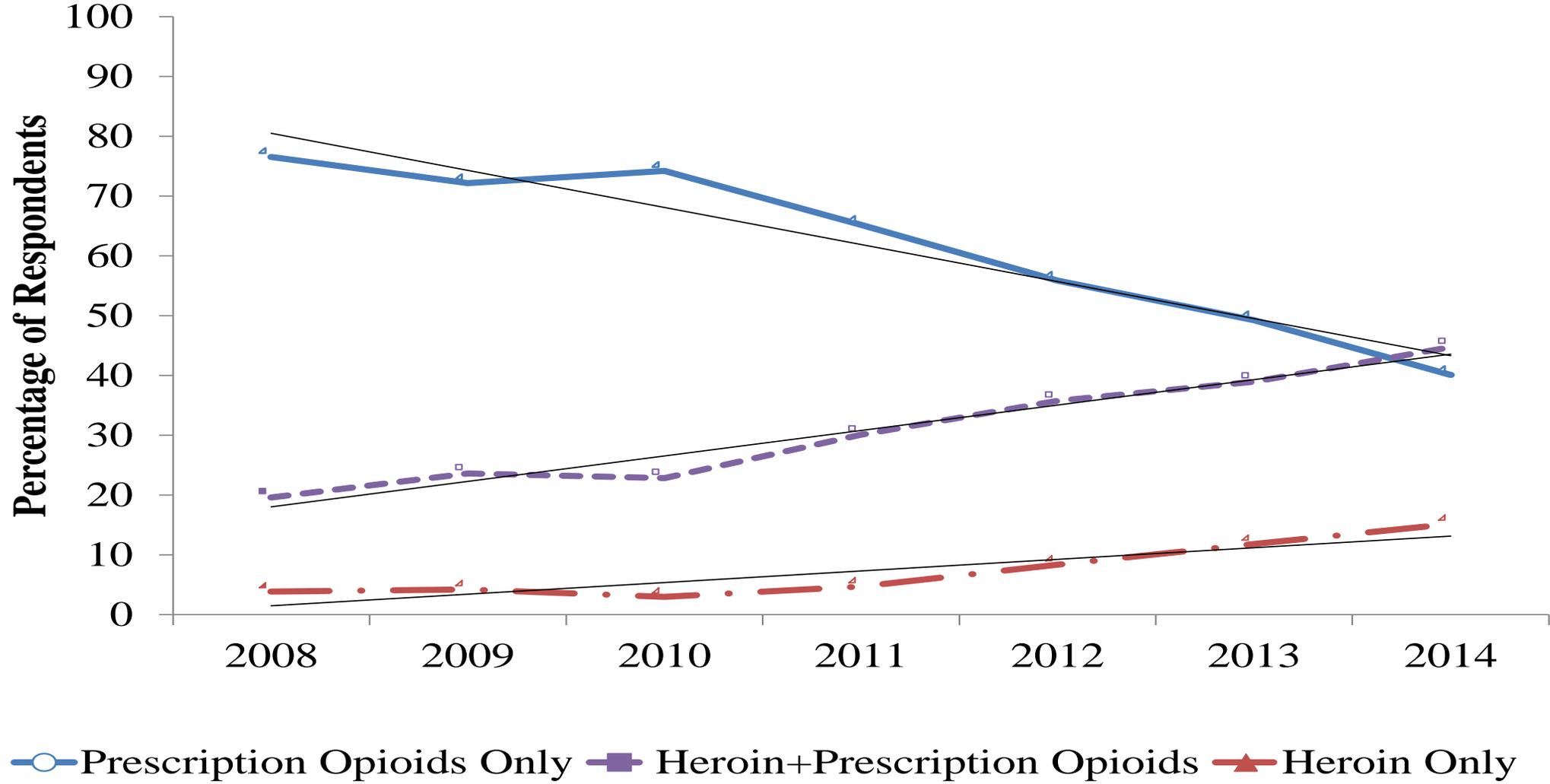
# C. South



○ Prescription Opioids Only   ■ Heroin+Prescription Opioids   ▲ Heroin Only



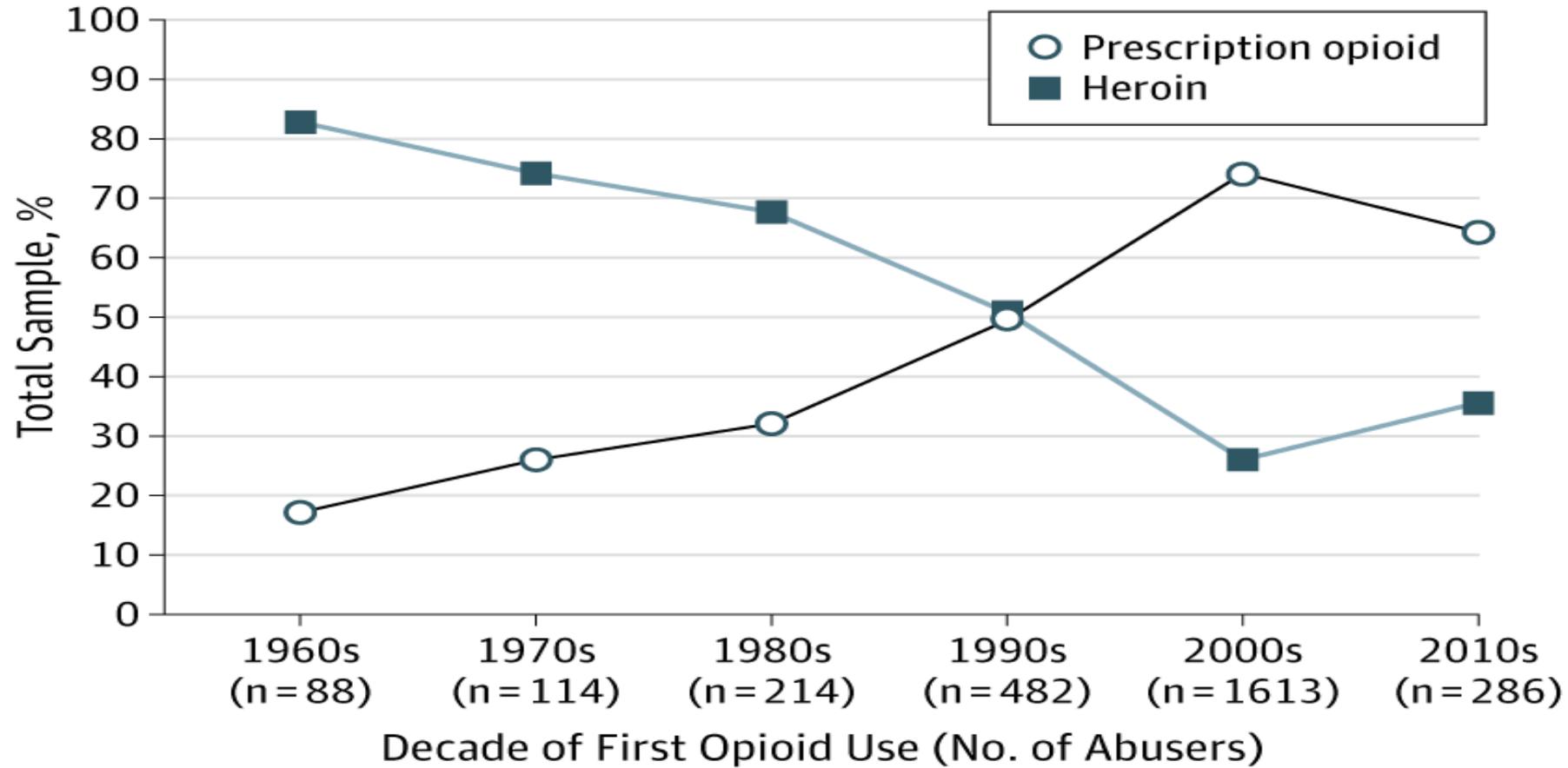
## D. West





Prescription opioids as a “gateway” to heroin.

# + First Drug Used

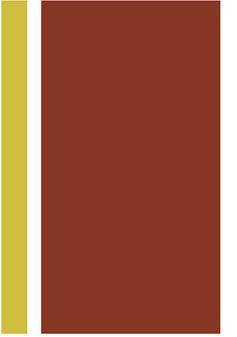




# Increases in Heroin: Why?

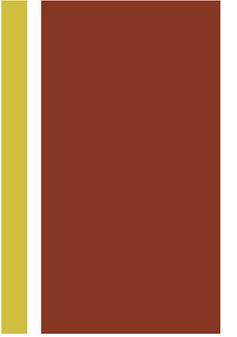


# Practical Factors



## ■ Prescription opioids

- Some are expensive or have seen prices increase.
- Many preferred opioids hard to find.
- Abuse deterrent formulations



- **Cost and availability.**
  - Heroin is cheaper.
  - Heroin is easier to get.
  - Heroin is easier to inject.
  - Heroin is purer than ever.



# Representative quotes



“Heroin is cheaper and stronger than prescription drugs, and the supply is typically pretty consistent. It is also much easier to use intravenously than pills and other prescriptions, which often take more complex methods to break down.”



“...it was cheaper and easier to get heroine [sic], which was much stronger and would get you higher than Oxycodone.”



# Evidence of Reduced Stigma



“...once one leaves the stigma of prescription vs. street drugs behind the question becomes more purely economic/pragmatic, what will keep me from withdrawal right now.”



“....The 2 dealers and the people around them are middle class white kids, not even kids we were all in the age range of 25-41. It just became easy, and we weren’t really looked at as being addicts because everyone thinks heroin addicts are all homeless, shady looking, dirty junkies.”



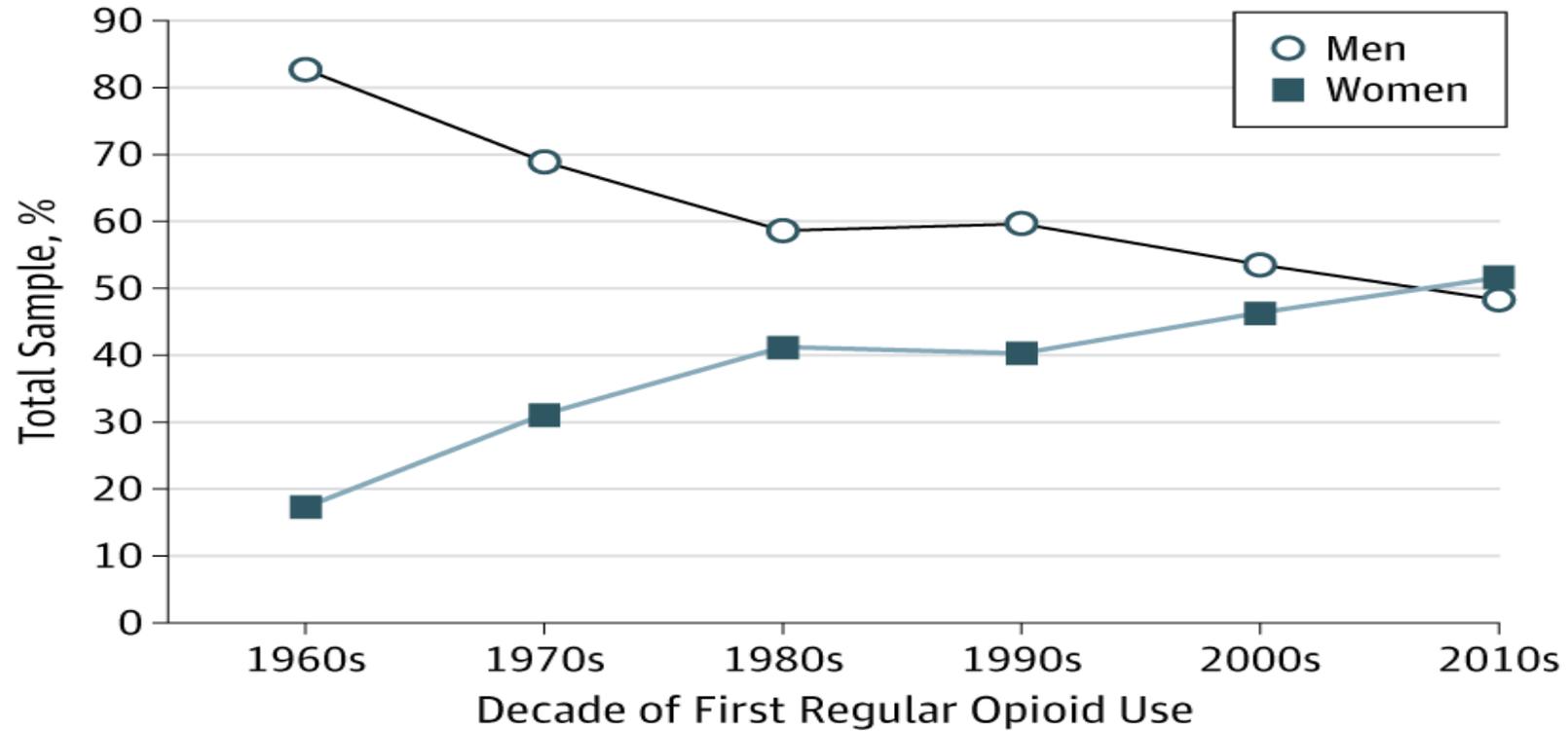
“I knew I liked it above all else, and once I had a drug dealer it became almost too easy to get.

I had access to money because I’m an upper middle class family and I also became close to my dealers, driving them around so I could get paid in drugs and just becoming super close, even if it meant sexually, so I could get the drug.....”

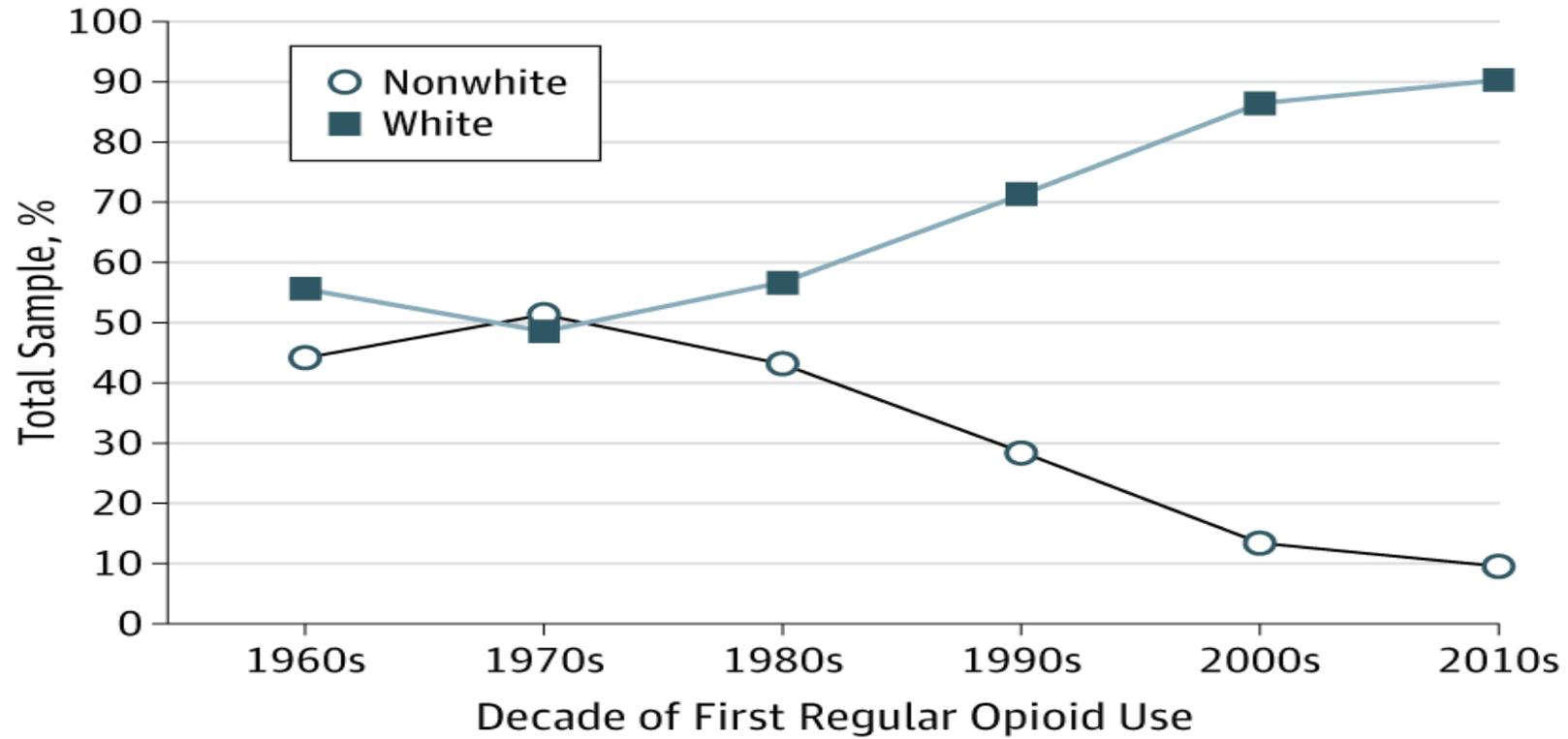


# Societal Impact: Changing Demographics

# + Changing Demographics



# + Changing Demographics

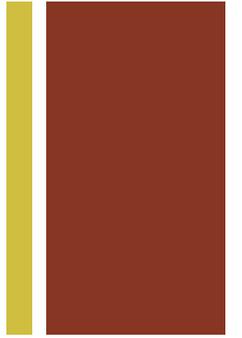


# + Changing Demographics

- Over 75% of heroin users in the past few years resided in suburban or rural areas.
- Previous heroin users:
  - Young, minority male living in an urban center.
- New heroin users:
  - Older, white male/female living in a suburban/rural area.



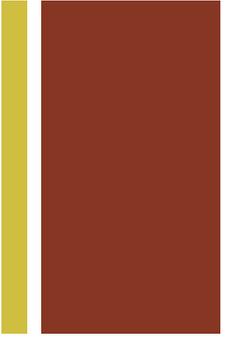
# Conclusions: “A Perfect Storm”



- Supply side efforts reduced availability and increased cost of prescription opioids.
  - Heroin is cheaper.
  - Heroin is easier to get.
  - Heroin is easier to inject.
  - Heroin is purer than ever.

# + Conclusions: “A Perfect Storm”

- Better “high.”
  - Balance of what makes you feel the best vs. practical issues (cost, etc.)
- Stigma has started to subside.



**The End**

# The Role of Pain, Pain Medicine & Physicians in the Treatment of Pain and Substance Use Disorders

William S. Jacobs, MD  
Chief of Addiction Medicine  
Medical College of Georgia  
Medical Director  
Bluff Plantation

**Pain:** An unpleasant and potentially disabling sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

**Acute pain** is the normal, predictable physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. Acute pain generally is time- limited, lasting six weeks or less.

**Chronic pain** is a state in which pain persists beyond the usual course of an acute disease or healing of an injury (e.g., more than three months). It may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over a period of months or years.

**Chronic non-cancer related pain** is chronic pain that is not associated with active cancer and does not occur at the end of life.

# Definitions of pain

## Pain

**An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (IASP 1994)**

## Chronic pain

### Traditionally

**Temporally as pain persisting for at least 3-6 months**

### ... and now

**Pain that extends beyond the period of tissue healing and/or with low levels of identified pathology that are insufficient to explain the presence and/or extent of the pain**

**Aberrant Substance Use Behaviors:** Behaviors that are outside the boundaries of the agreed-upon treatment plan. For example, obtaining prescriptions for the same or similar drugs from more than one physician or other health care provider without the treating physician's knowledge is aberrant behavior, as is use of illicit drugs.

**Abuse:** a maladaptive pattern of drug use that results in harm or places the individual at risk of harm. Abuse of a prescription medication involves its use in a manner that deviates from approved medical, legal, and social standards, generally to achieve a euphoric state ("high") or to sustain opioid addiction or that is other than the purpose for which the medication was prescribed.

**Addiction:** a primary, chronic, neurobiologic disease, whose development and manifestations are influenced by genetic, psychosocial, and environmental factors & characterized by behaviors that include impaired control over drug use, craving, compulsive use, and continued use despite harm.

a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations.

Federation of State Medical Boards  
MODEL POLICY ON THE USE OF OPIOID ANALGESICS IN THE TREATMENT OF  
CHRONIC PAIN  
July 2013

updated guidelines for assessing physicians' management of pain,  
so as to determine whether opioid analgesics are used in a manner that is both  
*medically appropriate*  
and  
*in compliance* with applicable state and federal laws & regulations.

Inadequate attention to initial assessment to determine if opioids are clinically indicated and to determine risks associated with their use in a particular individual with pain.

Not unlike many drugs used in medicine today, there are significant risks associated with opioids and therefore benefits must outweigh the risks.

Inadequate monitoring during the use of potentially abusable medications.

Opioids may be associated with addiction, drug abuse, aberrant behaviors, chemical coping and other dysfunctional behavioral problems, and some patients may benefit from opioid dose reductions or tapering or weaning off the opioid.

Inadequate attention to patient education and informed consent.

The decision to begin opioid therapy for chronic pain should be a shared decision of the physician and patient after a discussion of the risks and a clear understanding that the clinical basis for the use of these medications for chronic pain is limited, that some pain may worsen with opioids, and taking opioids with other substances or certain condition (i.e. sleep apnea, mental illness, pre-existing substance use disorder) may increase risk.

Unjustified dose escalation without adequate attention to risks or alternative treatments.

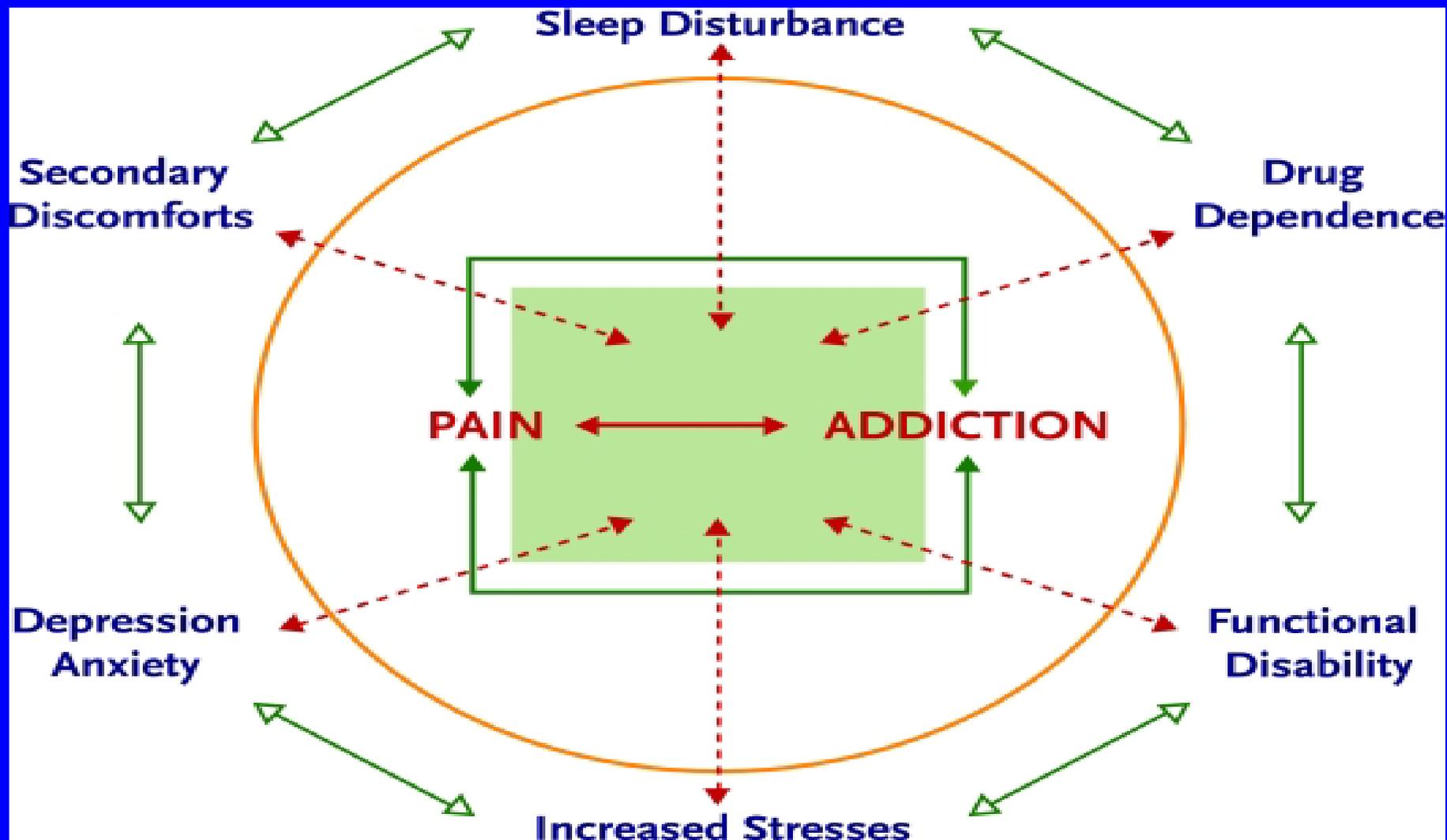
Risks associated with opioids increase with escalating doses as well as in the setting of other comorbidities (i.e. mental illness, respiratory disorders, pre-existing substance use disorder and sleep apnea) and with concurrent use with respiratory depressants such as benzodiazepines or alcohol.

Excessive reliance on opioids, particularly high dose opioids for chronic pain management.

Prescribers should be prepared for risk management with opioids in advance of prescribing and should use opioid therapy for chronic non-cancer pain only when safer and reasonably effective options have failed. Maintain opioid dosage as low as possible and continue only if clear and objective outcomes are being met.

Not making use of available tools for risk mitigations.

When available, the state prescription drug monitoring program should be checked in advance of prescribing opioids and should be available for ongoing monitoring.



[Challenges in Using Opioids to Treat Pain in Persons With Substance Use Disorders](#)

Seddon R. Savage, Kenneth L. Kirsh, Steven D. Passik

Addict Sci Clin Pract. 2008 June; 4(2): 4–25.

# Exhibit 1-1 Statistics on Substance Use and Chronic Pain in the United States



Category	Statistic
Chronic pain patients who may have addictive disorders	32% (Chelminski et al., 2005)
People ages 20 and older who report pain that lasted more than 3 months	56% (National Center for Health Statistics, 2006)
People experiencing disabling pain in the previous year	36% (Portenoy, Ugarte, Fuller, & Haas, 2004)
People ages 65 and older who experience pain that has lasted more than 12 months	57% (National Center for Health Statistics, 2006)
Civilian, noninstitutionalized U.S. residents ages 12 and older who report nonmedical use* of pain relievers in past year	5% (Substance Abuse and Mental Health Services Administration [SAMHSA], 2007)
People ages 12 and older who report that they initiated illegal drug use with pain relievers	19% (SAMHSA, 2008)
People with opioid addiction who report chronic pain	29–60% (Peles, Schreiber, Gordon, & Adelson, 2005; Potter, Shiffman, & Weiss, 2008; Rosenblum et al., 2003; Sheu et al., 2008)

\*Nonmedical use is use for purposes other than that for which the medication was prescribed.

## Patient Assessment

Patients should receive a comprehensive initial assessment.

It is important to discover the cause of a patient's chronic pain; however, clinicians should not assume a patient is disingenuous if the cause is not discovered.

The patient's personal and family substance use histories and current substance use patterns should be assessed.

It is crucial to obtain collateral information on the patient's pain level and functioning, as well as substance use disorder (SUD) status.

Comorbid psychological disorders should be assessed and treated.

Assessment of the patient with co-occurring chronic pain and SUD or other behavioral health disorders should be ongoing.

## Exhibit 2-1 Elements of a Comprehensive Patient Assessment

Element	Assessment Factor
Pain and Coping	<ul style="list-style-type: none"> <li>• Location, character (e.g., shooting or stinging, continuous or intermittent)</li> <li>• Pain types (i.e., nociceptive, neuropathic, mixed)</li> <li>• Lowest and highest extent of pain in a typical day, on a 0-to-10 scale</li> <li>• Usual pain in a typical day, on a 0-to-10 scale</li> <li>• When and how the pain started</li> <li>• Exacerbating factors (e.g., exertion/activity, food consumption, elimination, stress, medical issues)</li> <li>• Palliating factors (e.g., heat, cold, stretching, rest, medications, complementary and alternative treatments)</li> <li>• Prior evaluations to determine the source of pain</li> <li>• Response to previous pain treatments, including complementary and alternative treatments and interventional treatments</li> <li>• Goals and expectations for pain relief</li> </ul>
Collateral Information	<p>It is crucial to obtain such information as:</p> <ul style="list-style-type: none"> <li>• Findings of other clinicians, prior and current</li> <li>• Family concerns, beliefs, and observations</li> <li>• Pharmacist concerns, where relevant</li> <li>• Data from State electronic prescription monitoring programs, if available</li> <li>• Medical records, including psychiatric and substance use disorders (SUDs) treatment records</li> </ul>
Function	<p>Effect of pain on:</p> <ul style="list-style-type: none"> <li>• Activities of daily living/ability to care for oneself</li> <li>• Sleep</li> <li>• Mood</li> <li>• Work/household responsibilities</li> <li>• Sex</li> <li>• Socialization and support systems</li> <li>• Recreation</li> <li>• Goals and expectations for restored function</li> </ul>
Contingencies	<ul style="list-style-type: none"> <li>• Family support of wellness versus illness behavior</li> <li>• Vocational incentives and disincentives</li> <li>• Financial incentives and disincentives</li> <li>• Insurance/legal incentives and disincentives</li> <li>• Environmental and social resources for wellness</li> </ul>

## Exhibit 2-1 Elements of a Comprehensive Patient Assessment (continued)

Element	Assessment Factor
Substance Use History and Risk for Addiction	<ul style="list-style-type: none"> <li>• Current use of substances, including tobacco, alcohol, over-the-counter medications, prescription medications, and illicit drugs (confirmed by toxicology)</li> <li>• Focus on opioids to the exclusion of other treatments</li> <li>• Adverse consequences of use (e.g., functional impairment; legal, social, financial, family, work, medical problems)</li> <li>• Age at first use</li> <li>• Treatment history, including attendance at mutual-help groups</li> <li>• Periods of abstinence</li> <li>• Strength of recovery support network (e.g., sponsor, sober support network, mutual-help meetings)</li> <li>• Family history of SUD</li> <li>• History of physical, sexual, or emotional abuse or trauma</li> </ul>
Co-Occurring Conditions and Disorders	<ul style="list-style-type: none"> <li>• Psychological conditions (e.g., depression, anxiety, post-traumatic stress disorder [PTSD], somatoform disorders)</li> <li>• Medical conditions (e.g., hepatic, renal, cardiovascular, metabolic)</li> <li>• Cognitive impairments (e.g., dementia, delirium, intoxication, traumatic brain injury)</li> </ul>
Physical Exam	<ul style="list-style-type: none"> <li>• Relevant associated signs of pain disorder</li> <li>• Signs of substance abuse (e.g., track marks, hepatomegaly, residua of skin infections, nasal and oropharyngeal pathology)</li> </ul>
Mental Status	<ul style="list-style-type: none"> <li>• Medication focused</li> <li>• Somatic preoccupation</li> <li>• Mood</li> <li>• Suicidal ideation and behavior</li> <li>• Cognition (e.g., attentional capacity, memory)</li> </ul>

## Exhibit 2-2 Tools To Assess Pain Level

Tool	Strength	Weakness
Faces Pain Scale	<ul style="list-style-type: none"> <li>• Easy to use</li> <li>• Usable with people who have mild to moderate cognitive impairment</li> <li>• Translates across cultures and languages</li> </ul>	<ul style="list-style-type: none"> <li>• Visual impairment may affect accuracy or completion</li> <li>• May measure pain affect, not only pain intensity</li> </ul>
Numeric Rating Scale (NRS)	<ul style="list-style-type: none"> <li>• Easy to use if patient can translate pain into numbers</li> <li>• Easy to administer and score</li> <li>• Can measure small changes in pain intensity</li> <li>• Oral or written administration</li> <li>• Sensitive to changes in chronic pain</li> <li>• Translates across cultures and languages</li> </ul>	<ul style="list-style-type: none"> <li>• Difficult to administer to patients with cognitive impairments because of difficulty translating pain into numbers</li> </ul>
Verbal Rating Scale/Graphic Rating Scale	<ul style="list-style-type: none"> <li>• Easy to use</li> <li>• Oral or written administration</li> <li>• High completion rate with patients with cognitive impairments</li> <li>• Sensitive to change and validated for use with chronic pain</li> <li>• Correlates strongly with other tools</li> </ul>	<ul style="list-style-type: none"> <li>• Not as sensitive as NRS or Visual Analog Scale</li> </ul>

# Exhibit 2-2 Tools To Assess Pain Level (continued)

Tool	Strength	Weakness
Visual Analog Scale (VAS)	<ul style="list-style-type: none"><li>• Easy to use, but must be presented carefully</li><li>• Precise</li><li>• Sensitive to ethnic differences</li><li>• Easily translated across cultures and languages</li><li>• Some evidence that a horizontal line may be better than a vertical ("thermometer") orientation</li></ul>	<ul style="list-style-type: none"><li>• Visual impairment may affect accuracy</li><li>• Can be time consuming to score, unless mechanical or computerized VAS tools are used</li><li>• Low completion rate in patients with cognitive impairments</li><li>• Difficult to administer to patients with cognitive impairments</li><li>• Cannot be administered by phone or email</li><li>• Subject to measurement error</li></ul>

Bird, 2003; Brunton, 2004.

MODERATE

# UNIVERSAL PAIN ASSESSMENT TOOL

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0-10 Scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.

	0	1	2	3	4	5	6	7	8	9	10
<b>Verbal Descriptor Scale</b>	<b>NO PAIN</b>	<b>MILD PAIN</b>	<b>MODERATE PAIN</b>	<b>MODERATE PAIN</b>	<b>MODERATE PAIN</b>	<b>MODERATE PAIN</b>	<b>SEVERE PAIN</b>	<b>SEVERE PAIN</b>	<b>SEVERE PAIN</b>	<b>SEVERE PAIN</b>	<b>WORST PAIN POSSIBLE</b>
<b>WONG-BAKER FACIAL GRIMACE SCALE</b>											
	Alert smiling	No frown, narrow eyes	Furrowed brow, neutral eyes, neutral frowning	Wrinkled nose, raised brows, eye rapid blinking	Wrinkled nose, raised brows, eye rapid blinking	Wrinkled nose, raised brows, eye rapid blinking	Slow blink, open mouth	Eyes closed, moaning, crying			
<b>ACTIVITY TOLERANCE SCALE</b>	<b>NO PAIN</b>	<b>CAN BE IGNORED</b>	<b>INTERFERES WITH TASKS</b>	<b>INTERFERES WITH CONCENTRATION</b>	<b>INTERFERES WITH CONCENTRATION</b>	<b>INTERFERES WITH CONCENTRATION</b>	<b>INTERFERES WITH BASIC NEEDS</b>	<b>BEDREST REQUIRED</b>			
<b>SPANISH</b>	NADA DE DOLOR	UNPOQUITO DE DOLOR	UN DOLOR LEVE	DOLOR FUERTE	DOLOR FUERTE	DOLOR FUERTE	DOLOR DEMASIADO FUERTE	DOLOR DEMASIADO FUERTE	DOLOR DEMASIADO FUERTE	DOLOR DEMASIADO FUERTE	UN DOLOR INSOPORTABLE
<b>TAGALOG</b>	Walang Sakit	Kanting Sakit	Katamtamang Sakit	Matalimang Sakit	Matalimang Sakit	Matalimang Sakit	Pinaka-Matalimang Sakit	Pinaka-Matalimang Sakit	Pinaka-Matalimang Sakit	Pinaka-Matalimang Sakit	Pinaka-Matalimang Sakit
<b>CHINESE</b>	不痛	轻度	中度	重度	重度	重度	非常严重	非常严重	非常严重	非常严重	最严重
<b>KOREAN</b>	통증 없음	약한 통증	보통 통증	심한 통증	심한 통증	심한 통증	여우 심한 통증	여우 심한 통증	여우 심한 통증	여우 심한 통증	최악의 통증
<b>PERSIAN (FARSI)</b>	بدون درد	درد ملایم	درد معتدل	درد شدید	درد شدید	درد شدید	درد بسیار شدید	درد بسیار شدید	درد بسیار شدید	درد بسیار شدید	بدترین درد ممکن
<b>VIETNAMESE</b>	Không Đau	Đau Nhẹ	Đau Vừa Phải	Đau Nặng	Đau Nặng	Đau Nặng	Đau Thối Nặng	Đau Thối Nặng	Đau Thối Nặng	Đau Thối Nặng	Đau Bật Tận Cùng
<b>JAPANESE</b>	痛みがない	少し痛い	いくらか痛い	かなり痛い	かなり痛い	かなり痛い	ひどく痛い	ひどく痛い	ひどく痛い	ひどく痛い	ものすごく痛い

## Numeric Pain Intensity Scale

The typical numeric scale to gauge pain is from 0 to 10, with 0 being no pain, and 10 being very severe, intolerable level of pain. The scale below explains the numbers.

### Mankoski Pain Scale

0	Pain Free	No medication needed
1	Very minor annoyance-occasional minor twinges	No medication needed
2	Minor annoyance-occasional strong twinges	No medication needed
3	Annoying enough to be distracting	Mild painkillers are effective. (Aspirin, Ibuprofen)
4	Can be ignored if you are really involved in your work, but still distracting	Mild painkillers relieve pain for 3 to 4 hours
5	Can't be ignored for more than 30 minutes	Mild painkillers reduce pain for 3 to 4 hours
6	Can't be ignored for any length of time, but you can still go to work and participate in social activities	Stronger painkillers (Codeine, Vicodin) reduce pain for 3 to 4 hours
7	Makes it difficult to concentrate, interferes with sleep. You can still function with effort.	Stronger painkillers are only partially effective. Strongest painkillers relieve pain (Oxycontin, Morphine)
8	Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.	Stronger painkillers are minimally effective. Strongest painkillers reduce pain for 3 to 4 hours.
9	Unable to speak. Crying out or moaning uncontrollably - near delirium.	Strongest painkillers are only partially effective
10	Unconscious. Pain makes you pass out.	Strongest painkillers are only partially effective.

Average Pain level somewhere around here



Frequent spikes up to here



Source: [www.valis.com/andi/painscale](http://www.valis.com/andi/painscale)

## Exhibit 2-3 Tools To Assess Several Dimensions of Pain

Tool	Strength	Weakness
Brief Pain Inventory	<ul style="list-style-type: none"><li>• Short form better for clinical practice</li><li>• Fairly easy to use</li><li>• Useful in different cultures</li><li>• Translated into and validated in several languages</li></ul>	<ul style="list-style-type: none"><li>• Not easily used with patients with cognitive impairments</li></ul>
McGill Pain Questionnaire	<ul style="list-style-type: none"><li>• Short form easier to administer</li><li>• Extensively studied</li></ul>	<ul style="list-style-type: none"><li>• Measures pain affect</li><li>• Not appropriate for patients with cognitive impairments</li><li>• Translation complicated</li><li>• Meaning of pain descriptors may vary across racial and ethnic groups</li></ul>

# Exhibit 2-4 Tools To Assess Pain Interference With Life Activities and Functional Capacities

Tool	Purpose
Katz Basic Activities of Daily Living Scale	Rates independence by assessing six areas of daily activities
Pain Disability Index	Measures chronic pain and chronic pain interference in daily life
Roland-Morris Disability Questionnaire	Measures perceived disability from low back pain
WOMAC Index	Assesses pain, stiffness, and physical function in patients with osteoarthritis

## Exhibit 2-11 Tools To Assess Emotional Distress, Anxiety, Pain-Related Fear, and Depression

Tool	Purpose	Format	Administration Time
Beck Depression Inventory	Measures depression	21 items	10 minutes
Brief Patient Health Questionnaire	Measures depression, panic, stress, and women's health issues	9 items on depression, 1–5 items on panic, 13 items on stress, and 6 items on women's health	Varies
Center for Epidemiologic Studies Depression Scale	Measures how a patient has felt and behaved in past week	20 items	5–10 minutes
Geriatric Depression Scale	Seeks yes/no responses to measure depression in older adults	Short form: 15 items Long form: 30 items	5–10 minutes
Profile of Chronic Pain: Screen	Measures pain severity, interference, and emotional burden	15 items	5 minutes
Clinician Administered PTSD Scale	Assesses for PTSD symptoms, the effect of symptoms on individual's life, and the severity of symptoms	30 items	45 minutes or more
Davidson Trauma Scale	Measures frequency and severity of PTSD symptoms	17 items	10 minutes
Posttraumatic Diagnostic Scale	Assesses for PTSD symptoms and severity of symptoms	49 items	10-15 minutes
State-Trait Anxiety Inventory	Measures current anxiety and propensity for anxiety	40 items Self-administered	10–20 minutes
Tampa Scale for Kinesiophobia	Measures pain-related fear of movement; may predict disability	17 items Self-administered	5 minutes

# Exhibit 2-12 Tools To Assess Coping

Tool	Purpose	Format	Administration Time
Chronic Pain Acceptance Questionnaire	Assesses willingness to experience pain and engage in activities	20 items Self-administered	5 minutes
Fear-Avoidance Beliefs Questionnaire	Assesses patients who have chronic low-back pain	16 items Self-administered	10 minutes

## Exhibit 2-13 Risk of Patient's Developing Problematic Opioid Use

Risk	Characteristics of Patient
Low	No history of substance abuse Minimal, if any, risk factors
Medium	History of non-opioid SUD Family history of substance abuse Personal or family history of mental illness History of nonadherence to scheduled medication therapy Poorly characterized pain problem History of injection-related diseases History of multiple unexplained medical events (e.g., trauma, burns)
High	Active SUD History of prescription opioid abuse Patient previously assigned to medium risk exhibiting aberrant behaviors

Analgesic Research, personal communication, October 30, 2009.

# Screening and Opioid Assessment for Patients with Pain—Revised

SOAPP–R can predict which patients who have CNCP are at high risk for problems with chronic opioid therapy (Exhibit 2-14) (Butler, Fernandez, Benoit, Budman, & Jamison, 2008). It is a self-administered questionnaire answered on a 5-point scale ranging from 0 (never) to 4 (very often). The numeric ratings are added; a score of 18 or higher suggests the patient is at high risk for problems with chronic opioid therapy.

## Exhibit 2-14 SOAPP-R Questions

1. How often do you have mood swings?
2. How often have you felt a need for higher doses of medication to treat your pain?
3. How often have you felt impatient with your doctors?
4. How often have you felt that things are just too overwhelming that you can't handle them?
5. How often is there tension in the home?
6. How often have you counted pain pills to see how many are remaining?
7. How often have you been concerned that people will judge you for taking pain medication?
8. How often do you feel bored?
9. How often have you taken more pain medication than you were supposed to?
10. How often have you worried about being left alone?
11. How often have you felt a craving for medication?
12. How often have others expressed concern over your use of medication?
13. How often have any of your close friends had a problem with alcohol or drugs?
14. How often have others told you that you have a bad temper?
15. How often have you felt consumed by the need to get pain medication?
16. How often have you run out of pain medication early?
17. How often have others kept you from getting what you deserve?
18. How often, in your lifetime, have you had legal problems or been arrested?
19. How often have you attended an Alcoholics Anonymous or Narcotics Anonymous meeting?
20. How often have you been in an argument that was so out of control that someone got hurt?
21. How often have you been sexually abused?
22. How often have others suggested that you have a drug or alcohol problem?
23. How often have you had to borrow pain medications from your family or friends?
24. How often have you been treated for an alcohol or drug problem?

## | Opioid Risk Tool

Opioid Risk Tool (ORT; Webster & Webster, 2005) identifies patients at risk for aberrant drug-related behaviors (ADRBs) if prescribed opioids for CNCP (Exhibit 2-15). Like SOAPP-R, ORT may help clinicians decide which patients may require close monitoring if opioids are prescribed for them. Most patients who have CNCP and histories of behavioral health disorders are likely to have elevated scores, indicating a high level of risk on opioid therapy.

## Exhibit 2-15 ORT

Item	Mark Each Box That Applies	Item Score if Female	Item Score if Male
<b>1. Family history of substance abuse</b>			
Alcohol	<input type="checkbox"/>	1	3
Illegal drugs	<input type="checkbox"/>	2	3
Prescription drugs	<input type="checkbox"/>	4	4
<b>2. Personal history of substance abuse</b>			
Alcohol	<input type="checkbox"/>	3	3
Illegal drugs	<input type="checkbox"/>	4	4
Prescription drugs	<input type="checkbox"/>	5	5
<b>3. Age (mark box if 16–45)</b>	<input type="checkbox"/>	1	1
<b>4. History of preadolescent sexual abuse</b>	<input type="checkbox"/>	3	0
<b>5. Psychological disease</b>			
Attention deficit disorder, obsessive-compulsive disorder, bipolar, schizophrenia	<input type="checkbox"/>	2	2
<b>6. Depression</b>	<input type="checkbox"/>	1	1
<b>Total</b>		_____	_____
<b>Total score risk category</b>			
Low risk: 0–3			
Moderate risk: 4–7			
High risk: ≥ 8			



Webster, L. R., & Webster, R. M. (2005). Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the Opioid Risk Tool. *Pain Medicine, 6*(6), 432–442. Reproduced with permission of Blackwell Publishing, Ltd.

## Exhibit 2-16 Elements To Document During Patient Visits

Area	Elements of Documentation
History and Physical Evaluation	History of present illness Pain score/intensity Medication history SUD/addiction history Screening tool assessments Medical history Physical examination Mental status/cognition Results of diagnostic studies
Diagnostic/Clinical Indication for Prescribing Opioids	Most probable pathological explanation of chronic pain
Treatment Plan	Pharmacological treatments Nonpharmacological treatments (e.g., physical therapy, exercise, behavioral therapy, lifestyle changes) Treatment goals and anticipated time course Adherence measures (e.g., urine drug testing, pill counts)
Informed Consent and Agreements for Treatment	Informed consent (e.g., discussion of risks and benefits of treatment options) Agreement specifying patient's responsibilities and clinic policies
Periodic Review	Pain score/intensity Physical, occupational, and overall function; family and social relationships; and mood and sleep patterns Side effects (including severity) ADRBs Medication Mental status/cognitive changes
Consultations and referrals	As appropriate to provide comprehensive care



# Key Points

- Patients should receive a comprehensive initial assessment.
- It is important to discover the cause of a patient's chronic pain; however, clinicians should not assume a patient is disingenuous if the cause is not discovered.
- The patient's personal and family substance use histories and current substance use patterns should be assessed.
- It is crucial to obtain collateral information on the patient's pain level and functioning, as well as SUD status.
- Comorbid psychological disorders should be assessed and treated.
- Assessment of the patient with co-occurring chronic pain and SUD or other behavioral health disorders should be ongoing.



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