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Opioids & Chronic Non-Cancer Pain (CNCP) - What Can Pharmacists Do to Better Address Both "Pain" & "Addiction/Diversion" Concerns?

1) Always confirm patient identification (with photo ID if necessary) & check the medication record (i.e. PIP in SK). When necessary, collaborative information should be sought out to provide confirmation & further insight into information the patient gives.[1]

2) Consider where patients are in their journey with chronic pain. Assist patients in changing their mindset from "how much they suffer because of pain" to "how it is possible to live well even with chronic pain". Their suffering is real, but together with their health care team, supportive family & friends, they can regain a life worth living.

3) Counsel patient beyond the usual drug information, focusing on key issues surrounding chronic pain.
   a. Educate on the concept of an *opioid trial over several weeks* during which an evaluation of any potential benefits will be weighed against any potential harms.[2]
   b. Assess & correct patient expectations of opioid therapy as necessary.
      i. When effective, an opioid will allow for incremental gains in function.
      ii. Opioids will work for some patients, but not everyone.
      iii. Complete pain resolution is not a realistic expectation in CNCP.
      (A reduction in pain intensity of ≥30% reflects what is considered clinically significant. Clinical trials often use a ≥50% reduction in pain intensity as an indicator of efficacy.)
   c. CNCP is poorly responsive to opioid therapy alone; management requires concurrent multimodal therapies (e.g. conditioning along with pacing techniques, exercise, physiotherapy, cognitive behavioural therapy, relaxation, stress management).
   d. Assist patients to avoid becoming a target for drug theft. Counsel regarding secure storage options (e.g. lock box/cabinet) for opioids & the importance of not telling others that they are on opioids.[1] Offer to dispose of unused drug.

4) Ask the patient about functional goals; "what would success look like in your day-to-day life?"[2] Assist the patient in setting & focusing on these goals. Assist the healthcare team in monitoring these goals.✞

5) Reassess those with recurrent escalating doses without benefit, especially in terms of function.✞ Be alert for trends in deteriorating function & consider the "maximum dose" thresholds in CNCP. {≤90mg MEQ (morphine equivalent/day) in Canada;}[2] In patients who are "stable" at high doses (e.g ≥90 - 200mg MEQ), a dose reduction/taper should still be discussed, offered, attempted, and documented.

> *If a drug does more to you than for you, it's time to reassess therapy!*

6) Assist in contributing to, or coordinating new approaches & policies to deal with recurrent system challenges at a community level. It's likely that other physicians, pharmacists, nurses etc., are feeling the same frustration & may welcome coordinated efforts to better deal with the problem. [Sample clinic policy.[3]]

   Consider services you may offer as part of the patient's health care team:
   a. Offer to counsel regarding, & coordinate completion of, the "Patient Consent" &/or "Treatment Agreement" forms for chronic opioid therapy.[1,2,4] Assess addiction risk.✞,[2]
   b. May consider providing naloxone kits to patients at risk of overdose (e.g >90mg MEQ, aberrant behaviour, etc.) and educating patients, family, friends and other community members on how to use these kits effectively.
   c. Assist with goal setting, monitoring & documentation of progress over time.✞
   d. Provide formal/informal consultations regarding drug therapy to team members.
   e. Offer to provide "part-fills" e.g. weekly, or witnessed ingestion e.g. daily for a patient at higher risk of abuse or diversion.[1]
   f. Keep track of fill dates & notify physician of unusual trends; refuse to routinely fill early.[1]
   g. Offer to coordinate an "Opioid Patch Exchange" program for patients.[1,5] See ref for Link

7) Remember two noble purposes exist side by side: A) To treat chronic pain well, & B) To safeguard the patient & society from related harms.

✞ **See *Opioid Manager* tool**: http://nationalpaincentre.mcmaster.ca/opioidmanager/
See update: http://www.rxfiles.ca/rxfiles/uploads/documents/Opioids-Pain-2017-Newsletter.pdf

Note: the suggestions above are based on the following: **1)** Medications may be part of, although are often a small part of, the solution in CNCP; **2)** A trial of prescription opioids may lead to pain &/or function benefit in some CNCP patients; **3)** The statistics on Rx opioids available on the street or involved in overdose & death obligate health professionals to take greater precautions on behalf of a) their patients, b) their profession, & c) society; **4)** The more consistent, routine & universal the application of "best practice" safeguards, the easier it is to do in practice as it removes the stigma of "not being trusted"; **5)** Some of the recommendations will be easier to implement to a greater degree when practice within a healthcare team/primary care setting. **6)** Remember the need for balance in treating opioid patients with *respect*, *goodwill* & *good faith*, while maintaining *boundaries & a pragmatic approach*!!![6]

[1] Pain Approaches, from RxFiles Drug Comparison Charts: online at http://www.rxfiles.ca/rxfiles/uploads/documents/members/CHT-Pain-Approaches-Acute-Palliative-CNCP.pdf
[2] **Canadian Guideline for Safe & Effective Use of Opioids for Chronic Non-Cancer Pain.** Accessed June 2013 at http://nationalpaincentre.mcmaster.ca/opioid/
[3] Sample: Clinic Policy For Opioids & Controlled Drugs (RxFiles): http://www.rxfiles.ca/rxfiles/uploads/documents/members/Opioid-Controlled-Substance-Rx-Clinic-POLICY.pdf
[4] Sample: Patient Consent & Treatment Agreement: http://www.rxfiles.ca/rxfiles/uploads/documents/Pain-Opiod-Treatment-Agreement-Informed-Consent-2page.pdf
[5] Sample: Opioid Patch Exchange Disposal Tool (RxFiles): http://www.rxfiles.ca/rxfiles/uploads/documents/Opioid-Patch-Exchange-Disposal-Tool.pdf
[6] King NB, Fraser V. Untreated pain, narcotics regulation, and global health ideologies. PLoS Med. 2013 Apr;10(4):e1001411. doi: 10.1371/journal.pmed.1001411.