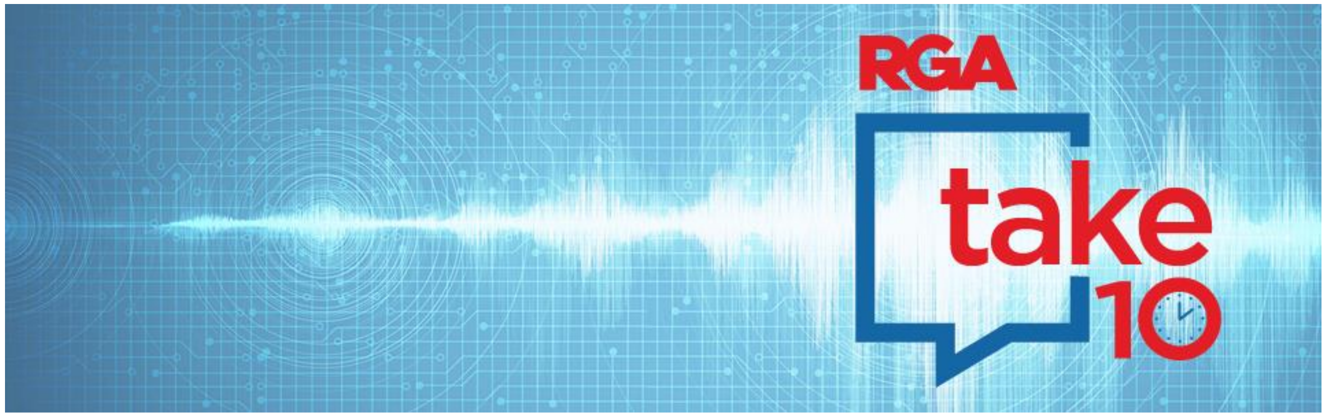

Long-term opioid use: dependence and addiction and the impacts on claims management

Take10 Podcast Transcript

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GK

Welcome back to RGA's Take10 podcast series, disability income claims in under 10 minutes. Sadly, disability and addiction are often seen together, with a person suffering from a disability, particularly a chronic pain condition, being at a far higher risk of suffering from an opioid addiction than someone without a disability. Statistics also show that opioid misuse has increased dramatically over the past decade and that both prescription and recreational opioid drugs have surpassed cocaine and heroin use as the leading drugs of abuse in many regions.

I'm Gayle Kanchanapume and with me today is Dr. James Kim.

Dr. Kim is the Medical Director of the Centre for Pain Management in Brampton, Canada and he is also a Medical Consultant to RGA. Welcome Dr. Kim.

JK

Pleasure.

GK

Dr Kim, can you talk to us a little of your experience as a medical practitioner interacting with patients suffering from addiction and tell us about some of the most commonly seen opioid misuse or abuse situations that you've encountered?

JK

Well, my current role as a chronic pain physician positions me at an intersection of pain and suffering that often requires the use of opioid based medications which can in and of themselves also arguably increase the medical burden through the risk of abuse through addiction and misuse. Now, before we go further, there are some distinctions that need to be spelled out regarding opioid addiction. There's that which is related to pharmaceutical

opioids prescribed or otherwise, and addiction related to illicit opioid narcotics. A lot of the news we hear about regarding the opioid crisis or opioid epidemic fail to differentiate between them although there is some definite overlap. Today we'll be discussing the former condition, pharmaceutical opioids, and specifically in the medical context of treating chronic pain and the reasons that an individual may misuse or become addicted to opioids.

It's an addiction as a complex phenomenon that is generated by a number of bio-psycho-social factors. In fact, the latest DSM5 definition encompasses this disorder as substance use disorder, stratifying it as mild, moderate, or severe, but more specifically it spells out opioid use disorder and lists the criteria for the application of this diagnosis. As a quick way of discerning what is addiction, it's defined clinically by the 4 C's: Compulsion leading to lack of Control, there's two C's there; Craving and continued use despite Consequences and those are the last two C's. Of the four C's, continued use despite consequences is the most telling factor that underlines an addiction issue.

So, in the context of prescription opioids, it can occur through a variety of mechanisms, undertreatment of pain, self-treatment of pain, poor coping mechanisms, problematic social dynamics, concurrent mental health conditions, such as depression, anxiety, and personality disorders, and epigenetics. All of these fall into the respective silos of the bio-psycho-social paradigm of chronic illness. Personally, from the standpoint of patients that I see and the statistics that have been put forth by different researchers, there's about a 5.5% chance of addiction to prescription opioids with about 10% of adults using prescription opioids, reporting some problematic behaviour, not necessarily all addiction based, but sometimes ones that may raise some red flags for the practicing physician.

So, if we were to put this into an epidemiological context, generally speaking, more women suffer from chronic pain than men; many patients are from a lower socioeconomic background; definitely smokers exhibit more chronic pain; and mental health comorbidities along with concurrent health conditions also impact this condition. But what is really important is the ideological basis for the chronic pain condition that engenders a host of factors which encompass what we're discussing about opioid dependence addiction and disability, leading to problems from a return to work perspective.

GK

Thanks for that Dr. Kim, that was really interesting. For a disability claim assessor, it may not often be easily identifiable that there's an opioid misuse issue potentially complicating the disability or impacting the treatment and recovery from the claim condition. Can you talk to us about some of the indicators that may be present in a disability claim setting, which could alert claims assessors to the existence of such an issue?

JK

Well, medical recognition of opioid addiction dependency arise from specific patterns of behaviour that are seen from a prescribing perspective. So, the physician will be the first person to notice this. Most often the earliest signs are requests for early repeats of medications for a number of different reasons, such as I lost them, they were stolen, dropped into the sink, so on so forth and other signs are requests for dose escalations. Now normally self-contained and limited requests are not of concern, but can be justified, however frequently repeated requests can point to problematic use. At the more extreme end of the spectrum, the patient is hospitalised for overdose through polypharmacy and excessive intake, and the physician finds out after the fact with the discharge summary reports that comes in the mail afterwards. The difficulty of dealing with opiate addiction in a chronic pain setting is and trying to determine the degree to which the actual underlying pain

condition is superimposed on the overlay of opioid use disorder. Having the confidence of the patient through a good therapeutic relationship and empathetic approach can enable a mutual understanding of the misuse problem that ultimately will harm the patient.

So traditionally opiate addiction and now opioid use disorder was treated by opioid substitution with methadone maintenance. The treatment would be provided by addiction treatment physicians and methadone clinics. And although the analgesic properties of the methadone also allow for treatment of concurrent pain, the methadone maintenance treatment was and still is stigmatising as it proffers a label of a drug user addict, because it is a fundamental regime for heroin addiction.

This entails also mandatory urine drug testing and witness dosing of the medication. Now methadone in itself has a relatively narrow therapeutic window of effect and requires careful monitoring. Currently Suboxone, a combination of Buprenorphine and Naloxone is now the preferred method for treating opioid use disorder and is arguably much safer.

Now, one of the things we talked about is the role of psychological interventions, however, at this point it is still an ancillary approach to medical treatment for biological addiction. The role of psychological support for outstanding psychosocial components obviously is important. And for this cognitive behavioural therapy is most often used.

Outside of that, insight and self-acknowledgement of the condition is essential in initiating treatment. A willingness to participate in a medical program of detoxification can only come about from a wilful desire to deal with the problem. This is the same for all addictions.

GK

Thanks for that. Now I'd be really interested to talk to you about some of the challenges that this presents for disability claims case managers. Perhaps you could share some strategies with us that case managers can put in place to assist them in navigating these during a claim?

JK

Well, there is often a confrontational and an adversarial view that patients have of claims assessors and the whole claims assessment process. A sense of dehumanization of the case to a binary outcome, either back at work or the push to return to work and the gradual escalation of requirements and considerations needed to maintain the disability status. This becomes a compounding source of stress and anxiety that further causes a separation between the mutual goals of having the patient have a proper outcome and to return to work and be productive. For such a sensitive case of opioid use disorder, a conscientious consideration of how this fit into the patients overall clinical condition and disability is paramount to engaging a buy-in with any plan to return to work.

Supportive actions and communications with the treating physician will help the patient see beyond a simple economic process, and, as mentioned before the underlying ideological basis for the chronic pain must also be considered, particularly if the pain arose from workplace injury. Fears of recurrent injury or persistence of the condition may be a significant barrier in return to work.

Sometimes separating the direct connection with the patient or the client by employing a rehabilitation consultant to help with the clinical recovery process may be important. This lessens the stress between the patient/client and the insurer.

I think that more consideration of the bigger picture may at the end, bring about a mutually beneficial outcome for both the patient's clinical condition as well as insurer in returning the patient back to work. I think that this it is probably something that is aligned with how the whole process of case management is proceeding and I think this type of condition, especially falls in line with that.

GK

Yes, that makes sense. I think with complex conditions like this, the key takeaway for me here is really trying to understand the full picture and what's going on behind, the initial injury or the cause of the chronic pain condition, but also your advice there about engaging appropriate support, so a rehabilitation consultant to help us navigate through that.

I'd like to thank you, Dr. Kim, for sharing your insights today and for talking to us about a very difficult, but very important topic.

Now this is the last episode of our current series of Take10, but keep an eye out for our next series, which will be coming later in 2021, and if you've missed any episodes in the series these are all available on the global claims manual/guide.

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