An Exploratory Study of Toxicology Screening Policies in Outpatient Pain Clinics

Graduate Thesis

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By

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Abstract

Objective:

The purpose of this study was to explore and compare the written and unwritten policies of outpatient pain clinics in the state of Ohio regarding positive toxicology screenings. Specifically, the study aimed to learn about the different approaches to toxicology screening in outpatient pain clinics, explore the procedures that outpatient pain clinics use following positive toxicology screenings, and gauge the extent to which outpatient pain clinics use written or unwritten policies in directing their actions following positive toxicology screenings. The research question was, *Is there a consistent manner or policy guiding the way in which positive urine tests are handled in pain management facilities?*

Methods:

Initially, a database was built listing one hundred Pain Management Centers or Departments in the state of Ohio using convenience sampling. This comprehensive list was derived from an Internet search and a variety of online directories. Researchers mailed surveys to the pain facilities listed in this database. Telephone calls were also made to each of these clinics prior to the mailing being sent. As a result, 35 (*N*=35) of these clinics responded providing insight into their respective clinics.
The researchers asked questions in order to better understand the practices and policies existing in the clinics surveyed. Such questions included inquiring about: the types or causes of pain treated in the clinics, frequency and types of toxicology screens utilized, what each clinic considers to be a positive toxicology screen, how these positive screens are handled and if a written policy exists in the clinic describing what to do when a patient produces a positive urine screen. These results were coded into an excel file and frequency distributions were calculated in order to create bar graphs to visually conceptualize these results.

Results:

The researchers found no consistent manner or policy in which positive urine tests are handled in pain management facilities in Ohio. There is no "gold standard" or best practice that is upheld in all clinics surveyed. Instead, the researchers found that typically, when in doubt, the physician decides how to handle these patients on a case by case basis.

Discussion:

With the continued prevalence of illegal and prescription drug abuse, misuse and diversion steps must be taken in order to minimize these occurrences. These findings suggest many implications for a variety of fields including medicine, nursing, addictions and social work. This will require physicians and
psychosocial teams to work together in order to determine how to most effectively handle this population that is commonly labeled, "complex patients."

It would be beneficial for universal policy to become more developed in this area taking into consideration perspectives from a variety of disciplines and applied in clinics not only statewide, but across the country. While a consistent approach is necessary, it could also prevent "doctor shopping" if all clinics employ the same expectations.

At the same time programming and expectations must be developed for those experiencing legitimate pain and who have a history of addiction, or are experiencing active addiction. As prescription drug misuse and abuse continues to become an escalating crisis, denying medications to individuals with pain who are suffering, violates the principles of justice and beneficence.
Dedication

This research is dedicated to those living with chronic pain; along with patients experiencing legitimate pain and have an alcohol or drug problem.
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Fields of Study

Major Field: Social Work
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Chapter 1: Introduction

“The use of opioids in pain management is a double-edged sword: while they are absolutely necessary to manage the pain and improve the function of many patients, their misuse is a significant national public health problem” (Hammett-Stabler & Webster, 2008, p. 2).

Pain clinics are healthcare facilities that specialize in the treatment of chronic pain. These clinics can be stand-alone facilities or part of larger healthcare facilities, such as hospitals. Pain clinics are becoming more and more common across the United States, with thousands of clinics nationwide and hundreds in the state of Ohio, alone.

Reisfield, Salazar, and Berholf (2007) found that, “Chronic pain affects one third of the US population and is a leading reason for physician visits” (p. 301). According to the Institute of Medicine of The National Academies (2011), chronic pain encompasses 100 million adult Americans, which equates to more than the total number of Americans experiencing Diabetes, Coronary Heart Disease, Stroke and Cancer (AAPM). The American Academy of Pain Medicine calculates that in 2010, the expenditure of health care (combining the medical expenses of pain care and the economic overheads related to disability days, lost pay and production) costs ranged from $560 billion to $635 billion.

The Office of National Drug Control Policy has gathered data from a variety of sources concerning prescription drug abuse. In the United States, prescription drugs are the second most abused substance following marijuana, the primary drug of choice (SAMHSA, 2010). These prescriptions also are contributing to the growing number of
drug related fatalities. In 2007, while 28,000 individuals in the United States died as the result of unintended drug poisoning, 12,000 of these involved prescription pain medications (National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2010). Concurrently, admissions to treatment for abusing pain medications in adults over 50 has increased from 0.7% in 1992 to 3.5% in 2008 (SAMHSA, 2009).

According to the Ohio Association of County Behavioral Health Authorities, “In 2010, the total number of doses of opiates that were prescribed in Ohio reached an astounding 776,163,404, or 67 doses for every man, women and child in Ohio” (2011).

Hammett-Stabler and Webster (2008), confirm that, “the basis for selecting, excluding, or terminating chronic pain patients from opioid treatment is not well-defined” (p. 3). They also found that the gender of the patient, the location of the pain, and opioids prescribed did not have a strong correlation to abnormal urine screens. Their research has found that relying on patient self reporting leads to deception; “physicians are particularly susceptible because they practice with a ‘truth bias’ – the physician-patient relationship is traditionally based on the physician accepting the veracity of a patient’s self-report” (p. 4). Additionally, they report that “researchers at Cornell University found that physicians detect a bogus patient only 10% of the time, even when warned of a visit by an actor with a ‘pain’ condition, in addition, physicians were liable to mistakenly identify real patients as actors” (p.4).

Pesce et al. (2011), quotes the National Drug Intelligence Center’s (NDIC) 2009 report on the drug threat assessment, “…abusers of Schedule II controlled prescription drugs usually acquire the drugs through traditional diversion methods such as
prescription fraud and doctor-shopping” (p. 190). This means that Schedule II substances being diverted on the street come from a legitimate physician.

It is common for these pain facilities to have patients sign a “treatment agreement” explaining the expectations of the clinic. These often include the following: no use of illegal drugs, no change in the dose of medications without a doctor's approval, no obtaining prescriptions from other sources, using one pharmacy, no early refills, and random urine testing (Schneider and Miller, 2008). Reisfield, Salazar, and Bertholf (2007) also stated in their article that, “a 1999 study by Fishman et al. revealed that a requirement to submit to random UDT was among the most common features of pain clinic opioid contracts” (p. 301). Manchikanti, et al. (2006), summarize that, “it is expected that random urine drug testing will deter use of illicit drugs, and also improve compliance” (p. 123). Additionally, Passick, et al.(2000) states, “When used appropriately, a UTS can help clinicians manage therapy with controlled prescription drugs” (p.41). This study seeks to define what “appropriately” means.

Heit and Gourlay (2004) state that, “The question of whom to test is made easier by having a uniform practice policy. By adopting a uniform policy of testing, stigma is reduced while ensuring that those persons dually diagnosed with pain and substance use disorders may receive optimal treatment. With careful explanation of the purpose of testing, any patient concerns can be easily addressed” (p. 262). Several articles across the board recommend random specimen collection as being best practice.

On the other hand, in 2004, Heit and Gourlay conducted, “a study that audited medical records to assess the management of chronic pain patients in family practices found that only 8% of physicians utilized UDT’s” (p, 260). These researchers found that
the use of UDT’s is often used to be disciplinary in order to find the patients with a positive or negative UDT when is should have been the opposite (p. 260). This study differentiated between forensic testing and compliance testing. Forensic testing is looking for substances that should not be in the urine. Compliance testing is to ensure that the correct substances are being found in the patient’s urine. “Thus, the appropriate use of a UDT result requires documentation in the medical record, and an understanding of how the results are to be used” (p. 261). This appears to be where physicians and psychosocial teams stray from a black and white, and slide into a gray area of uncertainty of how abnormal results should be utilized.

In a study conducted by Passick et al. (2000), it was discovered that, “The most important result of this survey was the poor documentation of the ordering and unsystematic use of the UTS (Urine Toxicology Screen). The UTS was often ordered without written justification and the results were rarely noted” (p. 43). They obviously suggested that testing have a systematic utilization, in addition to follow-up documentation for any changes in pain management. “Without more systematic use, the test may not be worth obtaining” (p. 43). Heit and Gourlay (2004) agree, “there must be a clear relationship between test results and subsequent actions taken by the treating practitioner” (p. 264).

Gilbert et al. (2010) claims that, “Identifying potential drug misuse early enables the practitioner to refer patients, sooner rather than later, to specialists in behavioral health care addiction medicine for potential treatment plan modifications” (p. 188). This study seeks to learn what these “modifications” include. To this extent, physicians must differentiate between addiction and pseudo-addiction. Specialists in behavioral health
care addiction medicine, often refuse to work with patients who are currently being prescribed opioids. Finally, for a patient in nearing end of life – what is more important to treat, an “addiction” or the pain?

Given the fact that treatment in pain clinics often includes prescription medications, toxicology screenings are utilized to determine whether patients are using non-prescribed medications, illicit drugs (e.g., marijuana, heroin), alcohol, an excess of their prescribed medication, or if the patient is not taking their prescribed medications at all. Schneider and Miller (2008) assert that, “The current recommendation is to do such screens initially and then subsequently on a random basis on all such patients” (p.62). While clinics generally use urine screenings, there are a number of options to test these samples, including, immunoassay and gas chromatography-mass spectrometry (GC-MS) tests (Moeller, Lee, & Kissack, 2008). The state of Ohio does not mandate testing or the types of tests that must be used, further contributing to the variability that exists in the industry. Hammett-Stabler and Webster (2008) confirm that there are three key essentials of urine drug testing that must be understood to utilize the testing in what is considered best practice in this setting. These essentials include the pharmacological characteristics of the drugs that the test is detecting, the connection of the “drug” to the person, and the investigation completed by the laboratory.

Unfortunately, little is known about the steps or actions that pain clinics take following positive toxicology screenings. In Hammett-Stabler and Webster’s 2008 article, they compare six separate pain clinic studies of urine drug screens. The results are displayed on the following page.
### Table 1. Comparison of Pain Clinic Studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Number of patients</th>
<th>Problem UDT results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ives TJ, et al. <em>BMC Health Serv Res.</em> 2006;6:46</td>
<td>186</td>
<td>62 (32%)</td>
</tr>
</tbody>
</table>

As displayed above, the number of patients with problem urine drug testing results is a problem. With this data, it makes sense to ask – what happens to these patients with problem urine drug testing results?

Again, the state of Ohio does not mandate the steps that should be taken when a patient has a positive screening. As such, pain clinics must formulate their own policies for the different positive screening scenarios (e.g., positive for alcohol; positive for non-prescribed medications; positive for illicit drugs).

Through the use of brief surveys sent to one hundred pain management facilities across Ohio, this study seeks to understand the toxicology screening procedures used by outpatient pain clinics and the policies that direct their actions following positive screenings. The findings from this study will shed light on ways that pain clinics address
this challenge. In addition, the findings may help policymakers gain a better understanding of the variability in policy and procedures and aid in the development of best practice guidelines.

This study seeks to understand the toxicology screening procedures used by outpatient pain clinics and written and unwritten policies that direct their actions following positive screenings. With the increasing numbers of pain pills being diverted into the community, along with number of overdoses occurring every year, and the growing addictions, we must do something in order to more closely monitor and consistently regulate the centers that are trying to provide care to those with legitimate pain and disease, along with those who have alcohol and drug problems.

The American Academy of Pain Medicine states that, “The ethical conduct of Pain Medicine practice should be uniform…” (p. 7). The data found in this study will show that while all pain management clinics are striving for the same goals, they do not all have the same policies and procedures. In fact, many of them lack written policies for the frequency of screenings along with consistent consequences for those who deviate from the expectations of the clinic and physician. “Physician discretion” can surprisingly present a variety of responses to these clinic issues.

Unfortunately, there is no united voice for pain management in our country. “Instead, we have a half-dozen professional organizations vying for funding of their members’ type of health care” (Loeser, 2006, p. 801).
Chapter 2: Literature Review

This chapter presents a review of the history and evolution of pain management and pain clinics up to the present time across the country and specifically in Ohio. The researcher will also provide an explanation for how pain has been treated over time, along with current legislation efforts. The chapter will conclude with details on the importance and rationale for this study.

Origins of Pain

There are a variety of types and causes of pain. Acute pain for example, is a normal feeling that informs your body of possible injury as the result of a stimulus. Neuropathic pain is due to “nerve injury, neurologic disease, or the involvement of nerves by other disease process” (Ballantyne & Mao, 2003, p. 1943). Chronic pain on the other hand, even if initially caused by a stimulus, goes on over time without reprieve. In fact, 116 million Americans suffer from chronic pain. This is more than double the number of people with diabetes, coronary heart disease, stroke, and cancer combined in the United States. Considering the mass of the population that chronic pain impacts, this is costing billions of dollars in medical care and economic costs (American Academy of Pain Medicine, 2011).
History of Pain Management Practice and Legislation

Pain is not a new problem that people are facing; however, the ways in which pain has been handled over time has changed. Brownstein suggests that perhaps initially, opium was used during religious rituals where religious figureheads, “representing gods who healed the sick and gods of death as well” (Brownstein, 1993, p. 5391). Opium was also provided to along with a poisonous plan in order to, “put people quickly and painlessly to death” (p. 5391). This led to the beginnings of its medicinal use.

Brownstein (1993) found that opium was found in India and China in the eighth century entering Asia and Europe through the thirteenth century; gradually expanding to the “privileged” in the United States and Europe (Ballantyne & Mao, 2003). In 1806, morphine was identified as opium’s active ingredient. “Morphine” was named after the “god of dreams” (Brownstein, p. 5391). With this substance, came experimentation and addiction.

Starting in the sixteenth century, manuscripts can be found describing drug abuse and tolerance in Turkey, Egypt, Germany, and England. Nowhere was the problem of addiction greater than in China where the practice of smoking opium began in the mid-seventeenth century after tobacco smoking was banned. Efforts to suppress the sale and use of opium failed because the British, later joined by the French, forced the Chinese to permit opium trade and consumption. (Brownstein, p. 5391)

Following the discovery of this substance, the “use of morphine-containing tinctures…became commonplace” (Ballantyne & Mao, 2003, p. 1943). This substance was used for a variety of conditions from boredom to colic, to other painful conditions
Ballantyne & Mao, 2003). In the 1850’s, when the hypodermic needle was created, “morphine began to be used for minor surgical procedures, for postoperative and chronic pain, and as an adjunct to general anesthetics” (Brownstein, p. 5391).

At the end of the 1800’s, as society began to discover that this substance could easily be abused, legal infractions were gradually established to prevent this occurrence. Other means of more non-addicting substances were research, and in 1989 heroin was made, found to be more powerful was labeled, “free from abuse liability” (Brownstein 1993, p. 5391). This claim was never proven to be true. In 1906 the Pure Food and Drug Act required that medications that contain opioids be labeled, this was later amended to include the quantity on the medication label (Dahl, 2003).

In the 1910’s, New York became the first state to endorse a Prescription Monitoring Program. It was not until the 1940’s that Hawaii and California followed suit, and only seven other states utilized this program by the 1980’s. These monitoring programs were established in order to gather prescription and distribution records from pharmacies, assess and make sense of patterns and forwards this information on to physicians and regulatory agencies. (Joranson et al, 2002, p. 232). Upon review of the patient’s habits, the physician or clinic may need to make an intervention. For example, if the monitoring program shows that the patient has been obtaining their medications from multiple providers, a urine test can verify if the medications are in their system along with how much of the medication is found. If the test proves to have the expected results, it would be up to the clinic to address with the patient where prescriptions obtained elsewhere are going.
In 1914 the first anti-narcotic legislated was put in place, called the Harrison Act. The purpose of this act was to end the non-medical consumption of opioids. Soon after, in 1919 it became illegal for general practitioners to prescribe opioid substances on the basis of maintaining an addiction (Dahl, 2003).

During World War II, methods of pain control consisted of, “the chemical and surgical interruption of ‘pain’ pathways” (Bonica, 1990, p. 368). This was initially utilized as anesthesia. It was at this time that surgeons and physicians from all over the world began to research and apply these “nerve blocks” to a variety of pain conditions. While conducting research, it became apparent that not all patients responded to these nerve blocks, these more complex patients were experiencing chronic pain. In conducting his research, Bonica worked with other medical colleagues from a variety of specialties. He found that by using this team approach in regards to complex pain patients, his practice was more “efficient and more effective that traditional medical practice” (p. 369). This was the beginning of the multidisciplinary team, “each member of which would contribute his/her specialized knowledge and skills to the common goal of making a correct diagnosis in developing the most effective therapeutic strategy” (p. 370).

In 1939, California instituted the first Multiple Copy Prescription Program (MCPP). The multiple copies consisted of one to stay with the prescribing physician, another to be sent to the pharmacist and kept on file there, and finally to a state regulating agency. This was the first step towards electronic monitoring (Dahl, 2003).

Gradually, (by the 1940’s) “opioids were so tightly restricted that they could be used legally only when they were prescribed by physicians according to strict regulatory controls” (Ballantyne & Mao, 2003, p. 1943). From then on, opioid use and prescription
disbursement is solely up to physicians. With this responsibility come consequences if inappropriate disbursement takes place. This could include sanctions such as loss of licensure and criminal prosecution. (p. 1943). With these guidelines in place, as a result many physicians were hesitant to prescribe such medications, and in some situations in such large supply.

The Single Convention on Narcotic Drugs was put into place in 1961 and later amended in 1972. This International Treaty restricted the manufacture, trade and allocation of medicinal narcotic drugs (Dahl, 2003). In 1962, The Food Drug and Cosmetic Act gave the United States Food and Drug Administration (FDA) the power to endorse drugs that are found to be safe and valuable in the medical realm. This left the Bureau of Narcotics and Dangerous Drugs (Department of Justice) in regulation of marijuana, cocaine and opioids, while the FDA focused on hallucinogens, stimulants and depressants (Dahl, 2003).

According to Bonica (1990), many of these pain clinics existed in the 1950’s, but fewer than five of these clinics employed a diverse multidisciplinary team. Bonica identifies that many advances were made in the 1970’s and 80’s, this includes the formation of multidisciplinary and interdisciplinary pain center (p. 370). Also during these two decades, publications were released that made many curious about pain, interventions, research and treatment. As a result of this surge in research, pain clinics were referred to as, “medicine’s new growth industry” (p. 371).

The Controlled Substances Act of 1970 formed a cataloged structure of drugs and substances used in controlled substances. This classification is broken into five schedules based on their probability for abuse or dependence in addition to their curative value.
While Schedule 2, 3, 4 and 5 substances can be accessed with a prescription; Schedule 1 substances (including marijuana and heroin) have no approved medical use in the United States at this time. Also in 1970, the Uniform Controlled Substances Act was enacted with the intentions of creating a standardized drug control policy and retract outdate regulations (Dahl, 2003).

In 1973, the DEA within the Department of Justice managed the CSA of 1970 and was responsible for registering all parties involved in the dispensing of controlled substances. The following year, Congress banned the prescribing of opioids with the intention of aiding the detoxification process in addition to addiction maintenance; however methadone was allowed (Dahl, 2003).

In 1984, the World Health Organization created the Analgesic Ladder, establishing that oral medications (for chronic pain) be taken on a regular and consistent basis, rather than as needed (O’Callaghan, p. 23). While ideally, this method should work, many cancer patients experience “breakthrough pain” which comes on suddenly, typically for brief periods of time and cannot be pacified by the persons typical pain management medications. For this reason, often another prescription is written to handle this random pain and should be taken as the breakthrough pain surfaces. In 1986, the DEA took responsibility over scheduling drugs and substances (Dahl, 2003).

By the end of the 1900’s, “opioid therapy was reestablished as an in valuable and accepted treatment for acute pain, pain due to cancer, and pain caused by terminal disease” (Ballantyne & Mao, 2003, p. 1943). Although, opioid therapy has become more accepted, many physicians remain hesitant of prescribing such medications. Some argue the efficacy of opioids on chronic pain in addition the side effects. On the other hand,
advocates have, “published consensus statements to guide physicians in prescribing these drugs. These consensus statements emphasize the importance of a standardized approach” (p. 1944). This journal article explains the specific steps of this ideally, consistent approach that should include an initial assessment that includes medical history, a basic physical exam, exhaust nonopioid therapy options, and establish goals of treatment. Treatment should ideally involve one physician and one pharmacy to obtain the best and most effective care. This physician should also reassess the progress or status of the goals of treatment in order to monitor opioid abuse, the option of utilizing alternative treatments, and plan of care when the opioids fail to meet the goals of treatment (p. 1944).

As of late 1990, Bonica (1990) estimates that two thousand pain facilities existed across thirty six countries, the majority being in the United States. In 1992, the first clinical practice guidelines were developed and presented by The Agency for Health Care Policy and Research. Since then, many other pain organizations have created their own more specific guidelines for a variety of disciplines and conditions. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), along with many other agencies have standards in place in order to promote proper and adequate pain management in a variety of settings. While these agencies provide standards, they do not include guidance on how to achieve these standards.

While these standards should be easily upheld in any and all clinics, “in busy practice settings, the reality of dealing with patients who have complex problems often forces physicians to compromise” (Ballantyne & Mao, p. 1951).
Hammett-Stabler & Webster (2008) believe that,

The use of opioids in pain management is a double-edged sword: while they are absolutely necessary to manage the pain and improve the function of many patients, their misuse is a significant national public health problem. (p.2)

In 1998 the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain was put into place by the Federation of State Medical Boards of the United States. These principles were put into place to ensure and protect the genuine medical need of controlled substance and concurrently being cautious of diversion and misuse (Dahl, 2003).

Nearing the year 2000, and increasing number of advocates surfaced and the use of opioids for “acute pain, pain due to cancer, and pain caused by a terminal disease” was reestablished as an valuable and customary treatment alternative (Ballantyne & Mao, 2003, p. 1943).

Pain Management Today

Today, according to the State Medical Board of Ohio, House Bill 93 defines a Pain Management Clinic as a facility that’s primary task is to provide care for patients with pain and receive treatment that may include controlled substances. The facility must also meet regulations established by the State Medical Board. These facilities must also become licensed as a Category III, terminal distributor of dangerous drugs with a pain management classification (ORC 4729.552).
Pain clinics are healthcare facilities that specialize in the treatment of chronic pain due to a variety of causes such as cancer, arthritis, lumbar, spinal, etc. These clinics can be inpatient or outpatient, stand-alone facilities or part of larger healthcare facilities, such as hospitals. Typically, these facilities prescribe medications, but do not however perform any medical procedures. Physicians in these clinics may have a variety of medical backgrounds including internal medicine, neurology, pain management, etc.

Patients are usually referred to these clinics by another provider who may not be proficient in pain management and may not be comfortable prescribing the large doses of opioids that is often times needed. Once a referral is obtained, the pain clinic may have a screening process before the prospective client is even seen to decide if they are a good fit for the clinic. Upon the patient’s first visit to the clinic, a physical exam is completed, along with a review of the patient’s medical history. An initial appointment often includes a social, psychological, and addictions assessment to gauge the patient’s risk factors.

A picture of the patient is often taken to add to the medical record. At this appointment, if the patient is going to be undergoing opioid therapy, they often are required to sign an agreement that lists the expectations of the clinic in addition to the consequences of failing to abide by these rules. These rules often prohibit the use of illicit drugs, altering the dose without consulting the physician first, visiting other pain physicians, early refills, and inform of the possibility of urine drug screens. After the initial appointment, patients are seen usually every two to six months for follow up.
Prevalence and Scope of the Problem

Pain clinics are becoming more and more common across the United States, with thousands of clinics nationwide and hundreds in the state of Ohio alone. It has been estimated that chronic pain directly affects one-third of the population (Reisfield, Salazar, & Berholf, 2007). In Ohio, it was estimated in 2010 that healthcare professionals prescribed over 776 million doses of pain medications, or 67 doses for every man, woman, and child in the state (Ohio Association of County Behavioral Health Authorities, 2011).

Unfortunately, “the basis for selecting, excluding, or terminating chronic pain patients from opioid (pain) treatment is not well-defined” (Hammett-Stabler & Webster, 2008, p.3). This is important because the misuse of pain medications and the effects of medication interactions can have catastrophic results for patients. Physicians often rely upon patient self-report in terms of the substances that they are using and the pain that patients are experiencing. Often patient self-report is a minimization of the actual substances being consumed. Tenore (2010) found that of 110 patients in a methadone clinic, nearly one fourth reported unlawful substance abuse in the month under review, yet toxicology reports showed that twice as many (39%) were actually using illegal substances. Additionally, in a study of more than 800 chronic opiate patients, nearly 200 were found to be using illicit substances, yet half of these patients steadfastly denied any substance abuse, even when assured anonymity (p.438). As a result of statistics like these, it is important to have another way of learning what the patient is ingesting (utilizing toxicology screens) other than relying on their own self-report.
Ethical Considerations

There are many ethical considerations concerning the treatment of those patients with chronic pain, with cancer, and in end of life care. According to the Hippocratic Oath, “Whatever houses I may visit, I will come for the benefit of the sick” (The American Academy of Pain Medicine, p. 9). Physicians may have ethical duties that differ from others on the multidisciplinary team. For example, Hank is a 70 year old man with end stage esophageal cancer. He no longer has an appetite and when he does eat he has trouble keeping his meals down. As a result he makes the decision to use marijuana. He claims that this has created an appetite that he hasn’t had since prior to his diagnosis and he is increasingly able to keep food down. He shares this with his pain management physician at this next appointment, and cannabis does in fact show up in his urine screen. Does the physician wean Hank off of his opioids as a result of violating his treatment agreement? Does the physician honor the American Medical Associations Principles of Medical Ethics that states, “A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient” by advocating? What if Hank has passed away by the time this legislation gets anywhere? Does the physician refer Hank to alcohol and drug treatment in this end of life stage he is entering? Does the physician turn a blind eye to this admission? Where do you draw the line? How many chances does someone get? What warrants discharge from a pain clinic?

According to the Hippocratic Oath, is it appropriate to deny a patient with legitimate pain proper opioid therapy or “the health of my patient will be my first consideration” (The American Academy of Pain Medicine, p. 9)? If Hank finds health
benefits in using marijuana, does the physician allow this since Hank’s quality of life seems to be improving even if it is illegal?

Compton (2008) confirms that:

Reactive discharge from opioid-analgesic therapy due to concerns about opioid addiction or abuse can do significant harm, not just at the level of the individual, but also affecting families, the healthcare system, and society at large. Such practice should be avoided. (Compton, p.1)

We must remember that, “Although all addicts are chemical copers, not all chemical copers are addicts” (Passik & Kirsh, 2008, p. 301). Pain management facilities must employ the proper multidisciplinary teams in order to provide patients with the appropriate support and counseling for coping with their diagnosis and prognosis in addition to other external stressors.

*Suggested Protocol for Opioid Therapy*

Ballantyne and Mao's 2003 article *Opioid Therapy for Chronic Pain*, published in the New England Journal of Medicine provides the table on page 17 laying out the suggested protocol for opioid therapy. Although Ballantyne and Mao's article was written nine years ago, the researchers were unable to locate any more current protocol progression. This table attempts to guide professionals through the decision phase, the dose-adjustment phase, the stable phase requiring monthly refills and comprehensive follow-up, through the possible outcomes that include successful treatment, dose escalation, and failed treatment. Toxicologic screening is only mentioned in the stable
phase during comprehensive follow-up. A similar protocol should be investigated and created for positive urine screens.

Table 2. Suggested Protocol for Opioid Therapy
The Role of Urine Toxicology Screens in Pain Management

Toxicology screenings are one of the more important components of these treatment agreements and one of the few objective methods through which pain clinics can monitor patients. Toxicology screenings are utilized to determine whether patients are using non-prescribed medications, illicit drugs (e.g., marijuana, heroin), alcohol, an excess of their prescribed medications, or if the patient is not taking their prescribed medications at all (Manchikanti et al., 2006; Passick, et al., 2000). Not taking prescribed medication could indicate that the patient is diverting his/her medication or prescription to others who do not have a prescription. In fact, between 1999 and 2002, the overdose death rate attributed to the diversion of prescription opioids grew by 91.2%. This indicates that, "a national epidemic of drug poisoning deaths began in the 1990’s and prescriptions for opioid analgesics contributed to the increases in drug poisoning deaths” (Tenore, 2010, p. 436-437).

The presence of illegal drugs in a urine screen indicates that these patients may not be able to be prescribed opioids without some type of intervention. There are many intervention possibilities including discharge from the clinic, a referral to alcohol and drug treatment, informing law enforcement, or some clinics choose to continue to work with these complex patients. Unfortunately, it is rare to find a treatment facility that will work with those actively being prescribed opioids due to having legitimate pain. This leaves a treatment gap in this portion of the population who has this legitimate need, but is additionally in need of alcohol and drug treatment. An appropriately staffed multidisciplinary team should have the resources available in their clinic or upon referral to treat these unique patients.
There are several different kinds of urine testing most commonly used in these clinics. Enzyme-Immuno Assay Testing (EIA) is the most common urine screen that is, “inexpensive, automated, rapid, and accurate” (Tenore, 2010, p. 437). This test is only able to recognize the class of drug and not the specific drug in the urine. Gas Chromatography and Mass Spectroscopy Testing allows the clinic to identify specific drugs and amounts in the patient.

In short, gas chromatography separates and quantifies drug components and then mass spectroscopy identifies them. Gas chromatography followed by mass spectrometry is considered the ‘gold standard’ of urine toxicology testing because it is 99% specific and 99% sensitive. (Tenore, 2010, p. 437-438)

Tenore discovered that chronic opioid patients in pain clinics have been found to provide noteworthy numbers of atypical urine screens. Tenore mentions one study that included several pain clinics where a fourth to half of the patients had been abusing substances and diverting prescription narcotics. These problems were correlated with specific aberrant behaviors for example: a pattern of losing prescriptions or frequent phone calls to the clinic, (just to name a few).

**Pseudo-addiction**

While many aberrant behaviors may suggest abuse or addiction, medical providers must also familiarize themselves with the term “pseudo-addiction”. Jamison et al. (2011) define *aberrant drug related behavior* as being, “suggestive of a substance abuse and/or addiction disorder.”
Compton (2008) states that, while none of these behaviors necessarily provide evidence of addiction, as a result patients may be discharged due to medication-misuse behaviors. But in actuality reflect possible pseudo-addiction (drug-seeking behaviors based on inadequate pain relief), a poorly treated Axis I or II psychiatric disorder, or general non-compliance with therapy (p.1).

Choosing to Discharge a Patient

Compton (2008) also argues that choosing to discharge a patient from opioid-analgesic therapy can do the patient, their family, the healthcare system and society more harm than good and that doing so should be avoided (p.1). We must become skilled at how clinics learn to handle and manage these complex patients that have a legitimate need for pain medications.

Even relatively severe drug-seeking behaviors in the context of a legitimate medical need, such as uncontrolled pain, cannot immediately be ascribed to addiction. The desperate search for pain relief, and the complex psychosocial disturbances accompanying chronic pain, may influence the phenomenology of drug use and greatly complicates the assessment of drug-related problems (DEA et al., 2011, p. 7).

As previously cited in the Ethical Consideration of the Literature Review, according to the Hippocratic Oath, is it appropriate to deny a patient with legitimate pain proper opioid therapy or “the health of my patient will be my first consideration” (The American Academy of Pain Medicine, p. 9)? Ethical considerations vary among positions
within the pain clinic i.e., social work values versus medical ethics. This can impact decision on when it is appropriate to legally discharge a patient from the clinic’s care.

**The Role of the Multidisciplinary Team**

Passick et al. (2000) stresses the importance of the role of the multidisciplinary team when managing substance abuse in the clinic setting. Using this resource and including mental health professionals is valuable in treatment compliance. It is important to note that while offering care to these complex patients, clinic employees may experience frustration that often leads to compromising the care that the patient receives. (p. 337). Passick et al. (2000) also stresses that clinic staff should not anticipate a total end to a substance use in patients with a history of drug use or addiction. “The distress of coping with a life-threatening illness and the availability of prescription drugs for symptom control can make complete abstinence an unrealistic goal.” Instead he suggests utilizing a harm reduction approach. While the use of urine toxicology screens is a helpful tool, recommending and documenting these tests, “tends to be inconsistent regarding the reasons for ordering as well as any follow-up recommendations based on the results” (p. 339). He identifies that some providers may turn a blind eye to the use of illegal drugs during end of life care in order for the patient to find pleasure during the end of life stage. Passick et al. also notes that this substance use can impact the efforts of palliative care (p. 340).
Utilization and Interpretation of Toxicology Screenings

While random toxicology screening is recommended, uniform policies do not exist across pain clinic settings (Moeller, et al., 2008; Schneider & Miller, 2008). In fact, one study found that only 8% of physicians treating pain utilized toxicology screenings. It also appears that physicians often lack a systematic method for administering random screenings, thereby limiting the effectiveness of this safeguard (Heit & Gourla, 2004; Passick et al., 2000). Tenore confirms this finding and states that, “It has been shown that physicians do not have proficiency in the ordering or interpretation of these tests” (2010).

Further contributing to this lack of uniformity, some states (including Ohio) do not mandate toxicology screenings or the types of tests that must be used. As such, pain clinics must formulate their own policies for the different positive screening scenarios (e.g., positive for alcohol, positive for non-prescribed medications; positive for illicit drugs).

In order for these toxicology test results to be considered in treatment decision-making, they must be read accurately. Tenore (2010) found that typically physicians specializing in primary care are not skilled at reading these results. In one particular study, of 80 physicians who completed a short, toxicology questionnaire, none of them answered all of the questions correctly and only a quarter of the physicians were correct on half or more of the questions. In a similar study, of 114 physicians questioned, only 30% answered half of the questions correctly. “The 77 physicians who used urine drug testing in their practices performed no better than the 37 physicians who did not…” (p.428).
There are many implications for tests not being interpreted correctly. For example, the simple EIA test mentioned earlier will not identify all “semi-synthetic” opiates, including oxycodone. Therefore, if someone prescribed and taking oxycodone is given the EIA test, and it does not show up in their urine, they are likely suspected of diverting their medications which could lead to being discharged from the clinic and not being permitted to receive any more opioids from that physician. However, there is a specific oxycodone EIA test that can more accurately confirm or deny what was found in the urine with the basic test. Other patients may false-negative oxycodone EIA’s that can be more accurately read with the gas chromatography and mass spectroscopy testing. There are specific EIA tests available for testing for oxycodone, buprenorphine and hydromorphone.

In summary, the common opiate EIA’s are able to detect morphine, heroin, hydrocodone, and codeine to produce a positive toxicology screen. To obtain more specific information or the concentration levels, the gas chromatography and mass spectroscopy test should be utilized (Tenore, 2010, p. 445).

According to Manchikanti et al., (2006) both prescription drug abuse and “illicit drug use are common in chronic pain patients” p.123). However, their study found, “significant reductions in illicit drug use with adherence monitoring combined with random urine drug testing in this population” (p.128).

*Vague Guidelines*

The American Pain Society and the American Academy of Pain Medicine Guidelines for the Use of Chronic Opioid Therapy (COT) in Chronic Noncancer Pain
state that, “In patients who are on COT who are at high risk or who have engaged in aberrant drug-related behaviors, clinicians should periodically obtain urine drug screens. In patients on COT not at high risk and not known to have engaged in aberrant behaviors, clinicians should consider periodically obtaining urine drug screens” (Bronstein, et al., 2010).

While these “guidelines” are in place, there are no definitions of “high risk”, what qualifies as being an “aberrant drug-related behavior”, and how frequently “periodic” urine screens should take place. Due to such vague guidelines, and no uniform risk assessment tool, we must question how consistently pain management clinics function across the state (not to mention the country).

Jamison, et al. (2011) states that, “Although there is no "gold standard" for opioid misuse risk assessment, several validated measures have been shown to be useful. Controlled substance agreements, regular urine drug screens, and interventions such as motivational counseling have been shown to help improve patient compliance with opioids and to minimize aberrant drug-related behavior.” (2011)

If these validated measures have indeed proven to be useful, why is there no industry ‘gold standard’? Surprisingly, the DEA reports that, “Self-report is the ‘gold standard’ for pain measurement” (DEA, et al., 2001, p.12) Self-report tools and scales can be easily manipulated and produce no “concrete” evidence of pain or medications or substances consumed.
**Preliminary Assessments**

Jamison, et al. (2011) states that those being considered for opioid treatment go through an intensive preliminary assessment. This evaluation should include a review of the patient’s medical history and records, a urine screen, routine physical exam and a psychological appraisal and screening. At this time any other prescribers that the patient has obtained controlled substances from should be shared with the prospective provider conducting the assessment.

One of the reasons that a psychological assessment should be completed is due to the fact that, nearly half of the patients experiencing chronic pain also have a psychiatric condition. Over half of chronic pain clinic patients surveyed showed signs, “of psychopathology, making this the most prevalent comorbidity in these patients. Studies suggest that most patients with chronic pain present with some psychiatric symptoms” (Jamison, et al., 2011).

**Physician Awareness**

Not only must patients be assessed for opioid therapy, physicians too must have the expertise needed to treat these complex patients. We must note that, “Not all pain specialists are knowledgeable or experienced in opioid therapy, for example, and not all provide access to psychological or rehabilitative treatments” (DEA et al., 2001, p.14).

In the Jamison et al., article, (2011), *Assessment and Treatment of Abuse Risk in Opioid Prescribing for Chronic Pain*, the researchers examined several urine toxicology results from pain clinics. In one, of 122 patients that were undergoing opioid therapy, 43% produced abnormal results. In another, 21% of patients not showing any aberrant
behaviors produced a positive urine screen for an illegal drug or a drug that they were not being prescribed. Bronstein et al., concur that while some physicians choose only to screen patients that they have suspicions about, they are overlooking a noteworthy segment of their patients that are in fact misusing their medications without showing any obvious aberrant behaviors (Bronstein, 2010).

While these results are not uncommon, we must balance the treatment of legitimate pain while at the same time, preventing diversion and misuse. (DEA et al., 2001, p.7). It is common for physicians to have realistic apprehension in regard to, the time/costs associated with treating these complex patients, perceived regulatory scrutiny, and patient noncompliance with the treatment regimen support terminating opioid therapy. Yet, summarily discharging these patients who may suffer an untreated and ultimately fatal disease (addiction) is, to this author, not only unethical but a source of significant harm. (Compton, 2008, p. 6).

Many physicians may fear that being “open” to working with these complex patients would require them to become an “addiction specialist.” Instead, a working relationship between the physician and an addiction specialist can allow for the continuation of needed medical and medicinal treatment while concurrently closely monitoring substance use. Compton confirms that, “Few resources for referral exist with the necessary expertise and capabilities required to treat addiction within the context of opioid therapy for chronic pain, either in the pain-or addiction-treatment systems” (Compton, 2008, p. 6).
Addiction Assessment

Compton (2008) promotes Savage's assessment of addiction in the pain management realm through using the “4 C’s”. This method consists of monitoring, “Negative Consequences of medication use, Loss of Control over use, Compulsive use, and Craving or preoccupation related to medication use” (p. 4).

Legislation and Monitoring

In 2005, The American Society of Interventional Pain Physicians (ASIPP) along with many practitioners worked on legislation in order to create the National All Schedules Prescription Electronic Reporting (NASPER) Act. This Act required the creation of a controlled substances monitoring program in each individual state.

As a result of NASPER, The Ohio Automated Rx Reporting System (OARRS) was created in 2006 in order to ensure that patients receive proper care and drug therapy, while at the same time recognizing drug seeking conduct and making certain that medications are being taken as prescribed. This information is accessible to prescribers, pharmacists and law enforcement.

In May of 2011, Ohio Governor Kasich signed House Bill 93 in conjunction with OAC 4729-5-20 Prospective Drug Utilization Review and OAC 4731-11-11 Standards and Procedures for Review of OARRS. HB 93 mandates that the State Medical Board, “adopt rules establishing standards to be followed by a physician regarding the review of patient information available through OARRS” (State Medical Board of Ohio).

While both OARRS and House Bill 93 set these expectations, there is no direction for how to handle aberrant drug seeking behaviors and positive urine screens. A
physician may review the OARRS report, but then what? Is there any agency that follows up with physicians serving “complex patients”? 

The Federation of State Medical Boards of the United States, Inc. created the Model Policy for the Use of Controlled Substances for the Treatment of Pain in May of 2004. The purpose of this document is to address the proper treatment of pain in conformity with laws and regulations. It states that, “…the federation aims to achieve more consistent policy in promotion of adequate pain management and education of the medical community about treating pain within the bounds of professional practice” (p.2). However, this text continues to be vague and lacking a “consistent” and “universal” policy. The only mention of urine testing is addressed under the title of informed consent required for obtaining urine and serum medication level as requested. What has to happen to require this request?

**Aim of Research**

The findings from this study will shed light on ways that pain clinics address these challenges. In addition, the findings may help policymakers gain a better understanding of the variability in policy and procedures and aid in the development of best practice guidelines.

With the trends that continue to escalate regarding the number of prescription pain prescriptions being written in addition to the number of these prescriptions being diverted and abused: we must strive to find the best practice for handling the prescribing of these substances, along with the gold standard for treating patients with legitimate pain that may in addition, have an alcohol and drug problem. Research must take place in order to
decrease these numbers and provide the appropriate care to the large number of patients across the country experiencing chronic pain.
Chapter 3: Methods

Research Question

The intent of this research is to better understand the policies and procedures of pain clinics, specifically in regards to urine drug testing. The specific research question is, Is there a consistent manner or policy in the way that positive urine tests are handled in pain management facilities?

Research Design

This study utilized a cross-sectional design to understand the practices, policies and procedures of urine drug screens in pain management facilities in order to explore how positive urine screens are addressed. Rubin and Babbie (2011) define a cross-sectional study as, “A study based on observations that represent a single point in time” (p. 620). A cross-sectional design was chosen because this data was preliminary, exploratory and observed the sample population at one specific point in time. An 11-item survey was developed by the researchers to learn more about how these "complex patients" are managed. This study is based on the 35 clinic respondents who chose to participate as a result of convenience sampling. Rubin and Babbie define convenience sampling (availability sampling) as, “A sampling method that selects elements simply because of their ready availability and convenience. Frequently used in social work
because it is usually less expensive than other methods and because other methods may
not be feasible for a particular type of study or population” (p. 617).

Sample Selection

Initially, a database was built listing one hundred Pain Management Centers or
Departments across the state of Ohio. This comprehensive list was derived from an
Internet search and a variety of online directories. The database included the name of the
clinic, address and phone number, a contact name (if available) along with two blank
columns for the researchers to fill in upon their first and second contact with the clinics.

A mailing was sent to these Clinics that included a cover letter (Appendix B), an
11-item standardized survey (Appendix C) and a stamped and self-addressed envelope
for the survey to be mailed back in to the researcher. Additionally, all of the clinics were
called, and two attempts were made to speak to each clinic for those the researcher was
unable to reach at their first attempt. Fourteen of these mailings were returned to the
researchers because those clinics no longer were at the address listed in the database.
Twenty-four clinics were interviewed on the phone, and eleven mailed completed surveys
back in the mail. Therefore, the findings discussed are based on a total of thirty-five
completed surveys.

Instrumentation

This method of research was chosen based upon the short time obligation that the
survey required from participants. This method also provided the pain clinics with the
necessary anonymity to share sensitive and potentially controversial information. The
survey (created by the researchers), consisted of eleven questions: two demographic
questions and nine basic informational questions. The two demographic questions sought
basic employee characteristics such as their position in the clinic and the years that they
have been employed with the clinic. The other questions included an inquiry about the
primary types of pain treated in the clinic, how often patients are given toxicology
screenings, the types of toxicology screens used in the clinic, what the facility considers a
“positive toxicology screening” along with the outcome when a patient produces a
positive screen. The questionnaire goes on to seek if there are standard procedures or
written policies that the staff follow, in addition to how they learned of these procedures.
The survey concluded with an area for the respondent to add any other comments. The
completed, anonymous surveys were coded and entered into an excel database in order to
complete the data analysis.

**Measures**

The measures questioned and considered in the survey represent a variety of
elements related to each pain facility and their practices, policies and procedures in
regards to patients producing positive urine screens for alcohol, illegal drugs, and the
misuse or abuse of prescription drugs.

- **Position at the clinic**

  The first question was left for the respondent to fill in the blank to insert his/her
  job title. Researchers were interested to learn the role of those completing the surveys for
a few reasons. One reason was to learn to different employee roles in the clinic and to see if there was one specific role that appeared to more often complete the questionnaires

- **Length of time employed by the clinic**

  Respondents were given a line to fill in the number of years and months that they had been employed by the clinic in question. Researchers chose to inquire about this topic to understand how long the majority of employee had been in the field, assuming that those who had been employed by the clinic longer would be more proficient and better able to answer the other questions on the survey.

- **Primary types and causes of pain treated at the clinic**

  The respondents were provided with checkboxes to mark the type or types of pain that their clinic treats. These categories included: cancer, arthritis, lumbar and spinal or other. The researchers were interested in this simply to see if there was much variation in the types of pain treated by the clinics surveyed.

- **Types of toxicology screens utilized at the clinic**

  The survey provided six checkboxes for the respondent to check which tests are utilized in their clinic. The possible responses included: immunoassays, mass spectrometry, GC/MS, LC/MS, don’t know and other. The researchers included this question to examine if one test was used more frequently than others and to if the staff had any awareness of the types of urine tests being completed in their clinic.
• **What the clinic considers a positive urine screen**

Again, six checkboxes were provided for the respondent to check one or more of the substances that the clinic is concerned about patients using. Possible responses included: alcohol, illegal drugs, misuse of prescription drugs, absence of prescription drugs, don’t know, a blank line was also provided to include any other substances that the clinic takes into consideration.

This measure was important to the researchers due to the existing discrepancy that not all clinics are concerned about the same substances. For example, not all clinics are concerned about alcohol use while a patient is receiving prescriptions for pain medications.

• **What happens when a patient has a positive toxicology screen**

Each substance (alcohol, illegal drugs, misuse or absence of prescription drugs) was listed on the questionnaire with a blank line next to each for the clinic to describe what intervention takes place after a positive urine screen. Different interventions may be standard for the clinic depending on the substance in question.

This was one of the most important questions on the survey in order for the researchers to determine and analyze whether any consistency exists among pain facilities regarding the manner in which these positive screens are handled.
- **Standard procedure that all staff follow**

  This question allowed for a “yes” or “no” response to be circled. Through these questions, the researchers hoped to determine whether or not a standard procedure was in place to guide the clinic treatment teams in decision making and intervention protocol.

- **Written policy**

  This question also allowed for a “yes” or “no” response to be circled. This was another very important measure for the researchers to determine if there was any solid, hard copy, agency standard to guide the clinic treatment teams in decision making and intervention protocol.

- **If the policy is not written, how it is learned**

  This question was followed by blank lines in order for the respondent to describe how their clinic trains their staff members on this “standard procedure”.

- **Additional thoughts**

  A space was provided for the survey respondents to write any other thoughts regarding the topic and survey that they completed. The researchers wanted to allow this space in order for the respondents to have the opportunity to speak freely and offer information not inquired about in the survey.
Data Analysis

The researchers had originally planned that this study would be qualitative; however after data was gathered, the responses did not provide enough depth for a qualitative analysis. Therefore, it was decided to conduct a quantitative study utilizing a cross-sectional design. Rubin and Babbie (2011) define a quantitative study as, “The numerical representation and manipulation of observations for the purpose of describing and explaining the phenomena that those observations reflect” (p. 627).

The coded data was entered into and analyzed using Microsoft Excel software. From this point, some category responses were condensed and frequency distributions were created for nine of the questions. The two open-ended questions were considered using a simple content analysis and supported the more quantitative findings. Bar graphs were created in order to visually summarize the data obtained.
Chapter 4: Results

The final sample consisted of 35 pain management facilities in the state of Ohio.

Table 1 below displays an overview of the learned practices and policies.

<table>
<thead>
<tr>
<th>Pain Clinic Patients, Practices and Policies (N=35)</th>
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<tbody>
<tr>
<td>Characteristics</td>
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<tr>
<td><strong>Frequency of toxicology screens</strong></td>
</tr>
<tr>
<td>Random</td>
</tr>
<tr>
<td>New patients &amp; random</td>
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<tr>
<td>Every 6 months</td>
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<td>New patients &amp; aberrant behaviors</td>
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<td>Every 3 months</td>
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<tr>
<td>All substances</td>
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<tr>
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If not written, how did you learn

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<td>18</td>
<td>51.4</td>
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Table 3. Pain Clinic Patients, Practices and Policies
Who Responded to the Survey?

A variety of pain clinic employees completed these interviews and surveys. These employees included: medical assistants, nurses, physicians, medical directors, specimen collectors, director of operations, office assistants, social workers and receptionists.

![Bar chart showing survey respondents](chart.png)

Figure 1. Survey Respondents

Six of the job titles were condensed into one miscellaneous category as a result of having only one of each respond: Specimen Collector, Director of Operations/Vice President of Nursing, Office Assistant, Social Worker, Receptionist and Coordinator.
How Long Have they Worked at the Clinic?

Each respondent had been employed at their respective clinics for a variety of time spans. The researchers had originally created categories of less than one year, one year, one and a half years, two years, etc and then ended up condensing the categories into less than a year, one to three years, four to six years, and seven or more years as displayed below.

Figure 2. Employment Longevity
What Types of Pain do these Facilities Treat?

The researchers inquired in regards to the primary types or causes of pain treated in each clinic. All but two of the clinics surveyed reported treating cancer pain, arthritis pain, lumbar and spinal pain, or all types of pain. Some clinics treated one specifically, or a variation of the four types. The majority of the facilities reported treating lumbar and spinal pain, the second more prominent category found that six clinics treated all types of pain.

![Figure 3. Types of Pain Treated](image)

Number of respondents
How Often are Toxicology Screens Administered?

Each clinic was asked how frequently patients were given a toxicology screen, and the researchers received a variety of responses ranging from new patients and randomly to as prescription refills were requested.

Figure 4. Frequency of Screening
What Types of Toxicology Screens are Utilized?

Clinics were also asked what types of toxicology screens they used in their clinics. An overwhelming majority were unaware of the types of testing that took place with the urine screens obtained from their patients.

Figure 5. Types of Toxicology Screens
What Substance(s) must be Present to be Considered a Positive Toxicology Screen?

The data gathered showed that different facilities have different views of what constitutes a positive urine screen. The survey offered the following possible responses: the presence of alcohol, illegal drugs, the misuse and/or abuse of prescribed medications. The majority considered all but alcohol to be a positive urine screen, although many also took all substances into deliberation.

Figure 6. Positive Toxicology Screens
What Happens When a Patient has a Positive Toxicology Screen?

The clinics were asked about what generally happens when a patient has a positive toxicology screen: this resulted in a large variety of treatment options which can be viewed in Appendix D.

Are These Standard Policies that the Staff Follows?

Respondents then were asked if the treatment options were standardized. The majority of facilities did in fact state that their practice followed standardized clinic policies.

![Are These Standard Policies that the Staff Follows?](image)

Figure 7. Standard Policy
Are These Standard Procedures from a Written Policy?

However, when asked if these standardized policies were written, we were surprised with the results. Interestingly, of the 35 clinics that responded to the survey, less than half of them reported having a written policy in their clinic regarding how positive toxicology screens should be handled.

Figure 8. Written Policy
If Not from a Written Policy, How did you Learn These Procedures?

The researchers then inquired about how these procedures are put into place if there is no written policy. The majority based their procedures and decision making upon physician and doctor discretion.

Figure 9. Training
Chapter 5: Discussion

The data findings proved that there is no consistent policy for handling positive urine tests in pain management facilities and in fact, the typical method of handling the test results is left up to the discretion of the physician. With so much relying on the discretion of the individual physician(s) at each clinic, as obtained in the data, there is very little consistency among clinics regarding how these urine screens should be handled.

Who responded to the survey? As seen in the results, a variety of staff employed at the clinics completed these surveys, the majority being the owner, medical director or practice manager. Only one social worker responded to this survey. Having only one social worker response creates a question concerning the role and presence of social workers in the pain clinic industry.

One would also think that pain clinics that commonly utilize urine drug testing would have one designated worker that would be responsible for such duties. This causes the researchers to question if these facilities typically employ specimen collectors and if there is a designated employee whose job is to conduct process and analyze these tests. On the other hand, it may be common for these clinics to send urine screens off site to be processed and analyzed at a lab that sends the clinic results.
At the same time, while perhaps one employee would complete the abovementioned tasks, it makes sense that the provider would decide what to do with the results. Ideally, perhaps this decision would or should be made as a team that would include the physician, the specimen collector, an addictionologist, licensed chemical dependency counselor, or social worker, and the psychosocial or multidisciplinary team. These results are consistent with the findings in the literature review, specifically from Bonica who also identified the value of a multidisciplinary team working together to serve and treat the patient as a whole.

How long have they worked at the clinic? The majority of these employees had worked in their respective clinics for four to six years. Seven of the respondents reported working in the facility for less than a year. This causes the researchers to question if this number of the respondents has only worked at the clinic for a year or less, how familiar are they with the policies and procedures of their clinics? On one hand, perhaps they are more familiar due to the assumption that they have been trained recently; but on the other hand, perhaps they have not completed a thorough training.

What types of pain do these facilities treat? The data showed that the clinics that chose to respond treat a variety of types and causes of pain, the majority revolving around lumbar and spinal, although commonly treating a combination of lumbar, spinal, arthritis and cancer pain. After learning about the stressors that come with chronic pain, it would be interesting to learn if there are any psychosocial stressors that are specific to these different origins of pain.
What types of toxicology screens are utilized? Of the respondents, 53% were unaware of the type of toxicology screen used in their clinic. It would have been interesting to learn if this result is due to urine specimens being sent to labs outside of the clinic or to being uninformed about this process. In addition, this research focused on urine toxicology screens due to its prevalence in practice and literature. In a future study, perhaps the researcher should explore what other methods are used in clinics besides the analyzing urine specimens. If this many respondents were unaware of what is used at their clinic, it would be curious to know if they are knowledgeable about how to read the results once a test has been analyzed.

How often are toxicology screens administered? The researchers found that there was also great variation in the regularity in which patients were given toxicology screenings. Consistent with Reisfield, Salazar and Bertholf’s 2007 findings that treatment agreements typically mention the clinic’s expectation for random urine screens; most frequently, first time patients were tested and from then on were tested on a random basis or as a result of displaying aberrant behaviors. These behaviors could include; selling or stealing prescriptions, buying prescriptions or medications on the street, using a family members prescription, illegal drug use, using more than prescribed, "losing" medications, having medications "stolen", attempting to obtain prescriptions from multiple providers, frequent requests for early prescription refills and frequency phone calls to the prescription line.

While many of these behaviors cause suspicion, it is not uncommon for some of the same aberrant behaviors to be attributed to a "pseudo-addiction." Pseudo-addiction
often results from having experienced poorly treated pain either in the past or currently. As a result of not having enough of or an appropriate pain regimen, or in fear of finding themselves in this situation, the individual displays behaviors that look similar to that of an addiction out of desperation or anticipation of unmanageable pain.

Agencies have standards for proper pain management but no guidance in regard to how to achieve those standards, i.e., the frequency of these screens. Just as a universal policy would be helpful in order to guide the interventions following a positive urine screen, a policy would also be beneficial regarding how frequently these screens should be requested from patients.

Practitioners must be aware that as the prevalence of prescription drug abuse continues to increase, that the "face" of those experiencing prescription pain addiction or diverting prescriptions is not what society has typically seen as a "drug addict" or "drug dealer". It is not unusual for these people to be living in middle and upper class neighborhoods whose children sit next to our children in class. Thus, practitioners cannot stereotype just one type of patient, and must realize that any patient in their practice could need assistance in regards to a problem with prescription drug abuse or diversion.

What substance(s) must be present to be considered a positive toxicology screen? As seen in the results, there was little variation in the definition of what these pain clinics consider a positive toxicology screen. Of the facilities, 14 took all substances into consideration, while 19 overlooked the use of alcohol. Only one respondent reported being unaware of what constitutes a positive screen. This is one question that did have
more consistency from clinic to clinic. It would have been interesting to learn why some clinics did not test or intervene with alcohol use in conjunction with the use of pain pills.

These findings reflect Heit and Gourlay’s 2004 study which utilized forensic testing to detect what was in the urine that should not have been, as well as compliance testing that looked for specific expected substances, such as appropriate levels of prescribed medications.

What happens when a patient has a positive toxicology screen? This question evoked a variety of answers. The responses, detailed in Appendix C, included anything from seven clinics which immediately discharged the patient from the clinic to giving multiple chances. Many of the responses indicated that this decision was left solely up to the physician. Many clinics indicated that they had given multiple chances for improvement and had referred patients to alcohol and drug treatment. This presents a unique problem because rarely will a substance abuse treatment facility work with patients being prescribed opioids. As a result, many patients are referred to psychologists and/or addictionologists within the clinic for counseling or alternative treatments. Some patients who are suspected of selling their prescriptions or misusing their pills may be required to bring them in to be counted at appointments or to bring documentation of a police report being filed for stolen medications. Ideally, the illegal drug category in this study should have been broken down into specific substances, e.g. marijuana, cocaine, and heroin, since there are more leniencies with the use of marijuana. No indications were found in the literature review which directed or guided clinics regarding the handling of positive urine screens.
Are these standard policies that the staff follows? Are these standard procedures from a written policy? While 83% of clinics reported that there are standard procedures that the staff follows regarding what happens when a patient has a positive toxicology screen, only 46% actually have a written policy. Without a written policy in place, the researchers must question how effective an unwritten standard policy can be. A basis for selecting, excluding or terminating is not well defined in the literature according to Hammet-Staber and Webster (2008). While the suggested protocol in Table 2 suggests toxicologic screening, if indicated, there is no direction guiding how to handle the results i.e., a positive urine screen.

*Implications for social work*

As Altilio (2007) states, "Social work, with its tradition and commitment to social justice, respect for persons, advocacy, and empowerment, has an opportunity to embrace issues reflected in the complex questions that relate to pain management." Those with a need for pain management interventions not only are experiencing physical pain, but are also increasingly prone to emotional and spiritual distress. In order for pain management facilities to provide the best care, patients must be treated as a whole, taking into consideration these existential issues that ultimately contribute to their physical pain and suffering. By addressing the patient and their needs as a whole, pain professionals can impact and maximize the individual’s quality of life.

Pain treatment and medications can be difficult to obtain for a variety of reasons including mistaken beliefs or impressions about opioid use and addiction, unequal access and insufficient healthcare for the underprivileged, regulatory obstacle, and ineffective
instruction of healthcare practitioners about their professional and ethical duty to effectively treat pain (Altilio, 2007). Social workers in the pain management realm can help patients to break down these barriers to obtain the care and relief that they need and deserve regardless of their income or history.

Pain is commonly perceived on an individualized basis that is built upon an array of variables not just limited to physicality, but expanding to psychosomatic issues, family and support system availability along with socioeconomic and Axis IV psychosocial and environmental problems. Just psychosocial issues can impact pain, pain can also impact psychosocial issues that are not just contained in the patient, but often reach caregivers and family.

Obviously, this can make it very difficult for a physician to accurately gauge and treat an individual's pain and could greatly benefit from a social worker to help to address these non-physical issues. Altilio (2007) confirms that, "Pain is best treated in the setting of a multidimensional assessment where the complex interplay between biological, medical, social, religious/spiritual, psychological, and cognitive/behavioral dimensions is understood and incorporated into the treatment approach" (p. 44).

Treatment goals should not be simply to treat one's pain, but should also include psychosocial work in order to help individuals adjust to new ways of functioning and enhancing overall quality of life. This acknowledgement and assistance of adjustment requires processing feelings of loss and adaptation through a variety of clinical interventions.

Anxiety, addiction, depression and other psychiatric concerns can aggravate an individual's pain and entail proficient evaluation for the treatment plan to address all
facets of the problem. Pain may coexist with anguish and psychiatric indications, or may be disconnected. Hopelessness and worry may be pre-existing conditions or a result of living with pain. The clinical mission is to prioritize the issues and when necessary, to generate a treatment plan that respond to and addresses the person as a whole (Altilio, 2007, p. 44).

From the social work, "person in environment" perspective, serving as an umbrella to social, economic, cultural, spiritual, psychological, emotional and environmental avenues, in the context of pain management in particular, we should be able to move beyond the medical model and breakthrough to a more multidimensional focus in order to treat the person as a whole. This should include helping patients to adjust and adapt to a new quality of life and a new "normal". Psychosocial issues include psychological, emotional, anxiety, depression and addiction, in addition to social and spiritual well being. Environmental concerns often exist related to economic and cultural settings. Not only does this treatment impact the patient, but also the caregiver who often becomes responsible for medication management, cooking, cleaning, bathing, and transporting the patient to various appointments or treatments. Social worker's participate in breaking down the barriers and advocating for healthcare and financial resources for those most in need. Unfortunately, unequal access to services and insufficient healthcare often gets in the way of proper treatment and care. Social work also expands into advocacy and policy and as noted, there is a need for this in pain management to work with the both the staff of a clinic in partnership with the patient's that are served.

Because of current economic circumstances along with barriers to appropriate insurance coverage, members of society from any class are commonly running into
financial struggles as costs surface to cover prescriptions, medical procedures, medical treatments, medical appointments, in addition to individuals pre-existing financial obligations. As a result, many patients in this predicament find themselves with no choice but to sell their belongings and homes or give things away in order for government and community welfare agencies to find them eligible for assistance. This is impacting individuals and families from all walks of life and income brackets. Naturally, this is disconcerting for people who are well educated and have worked throughout their lives to have to give up so much in order to obtain much needed assistance. Individual's income should not impact the medical care and treatment that these patients receive, everyone deserves to have the same level of care and access to resources.

"As pain has moved beyond the physical to a biopsychosocial, spiritual model, it has also become the focus of the media, legislators, and litigators. The landscape of opportunity for social work involvement has broadened and, if we hear it, there is a loud invitation for social work to respond. At the same time, the vulnerability of persons living with pain increases and social work participation in this rich and complex issue has the potential to make a critical impact" (Altilio, 2007, p. 44).

As addressed earlier, there are many implications among these findings for the field of social work. For example, the majority of patients utilizing pain management centers do have legitimate pain. However, there are very few (if any) recovery services in the state for those that are experiencing legitimate pain and have a problem with alcohol or other drugs that will allow the client to continue with their necessary pain regimen and also pursue alcohol or drug treatment concurrently. If more social workers were trained in working with this complex patient population, perhaps there would be more opportunities
to serve the diverse needs of these patients. This would require that physicians work together with social workers or on multidisciplinary teams to create an appropriate treatment plan that everyone could agree upon without enabling the patient or leaving their pain untreated.

Policy

Policy must exist to allow all patients in need, access to sufficient healthcare. It should include physician visits, psychosocial visits, treatments, medications, and transportation. Policy should also make mandatory the use of, or contact with, a multidisciplinary team to treat the person as a whole and not just his/her pain. Uniform policy must exist to allow appropriate and equal treatment to all in need and to minimize stigma.

It will be important for social work training to include education on topics related to working with a multidisciplinary team and policies that may not parallel with other professions in the clinic setting. This should create dialogue among the parties involved in a patients care.

Policy and research must be standardized for the use of marijuana in pain management facilities. This should be consistent nationwide in order to prevent doctor shopping from state to state. Policy must also guide clinics on handling “complex” patients without passing them on to another facility. These patients are manageable with the appropriate interventions.
Limitations

While the researchers were able to find some themes and patterns in the results, there were many limitations of the study. Ideally the study should have had a larger sample size, therefore making it difficult to generalize trends from such a small sample size. Additionally, this was a geographically limited sample looking only at the state of Ohio. As a result, caution should be used in generalizing the study results to other areas of the country. Rubin and Babbie (2011) define generalizability as, “That quality of a research finding that justifies the inference that it represents something more than the specific observations on which it was based” (p. 622).

The researchers utilized convenience sampling and as a result there may be some response bias. This means that only some types of facilities may have responded while some may have avoided completing the survey all together. There is a likelihood of increased response bias due to the fact that the survey was inquiring regarding controversial topics and respondents may have felt pressure to provide socially acceptable answers. This could have also contributed to social desirability bias where the respondent may have answered the questions in a manner that they think is most politically correct or socially accepted, regardless of the real policies (or lack of) actually taking place within the clinic. Non-response bias could have also impacted the results of this study as a result of the number of clinics that chose not to participate in the study, as a result of only nearly one third of the clinics participated in the research.

The researchers had also planned for this study to produce qualitative results, but once the data was gathered, the surveys did not produce enough data in depth and so the
researchers switched to a more quantitative study. This exploratory study sought to understand and investigate policy, with resulted in simple descriptive statistics.

As the result of conducting a cross sectional study, the researchers were only able to capture a "snapshot in time" and is unable to track change over time rather than seeing trends in the individual clinics over time or even "following" a handful of patients from their initial appointment over an extended period of time (six months or a year). The researchers also utilized a variety of data collection methods; some of the surveys were administered by the researcher over the phone while the surveys sent through the mail were self-administered. This could potentially have caused differences in the information that was reported.
Chapter 6: Conclusion

Through this study, the researchers were able to gain initial insight into practice and policies, written or unwritten, taking place in pain management facilities in Ohio regarding positive urine toxicology screens. The original research question was, *Is there a consistent manner or policy guiding the way in which positive urine tests are handled in pain management facilities?*

The researchers found much variation in the response for what happens when a patient produces a positive screen, although seven (20%) of the 35 (N=35) reported an immediate discharge from the clinic. The majority reported treating mainly lumbar and spinal pain. While 51% of the respondents were unaware of the type toxicology screen they utilized in their clinic, the majority administered these screens on a random basis. The researchers found that 54% of clinics surveyed considered screens to be positive that contained illegal drugs, too much or too little of a prescribed medication, or the presence of un-prescribed medications. However, this 54% did not consider the presence of alcohol to be a positive urine screen. On the other hand, 40% did include alcohol in their consideration of a positive screen. Finally, while 83% reported that treatment options were standard policies that the staff follow regarding positive urine screens, only 46% reported that these procedures were written in an actual policy.
Future Research

While the above results were found, more questions and areas for future research were discovered:

- Many patients who are being seen in pain management clinics are approaching the end of life and receiving palliative care. This presents a unique problem to the physicians and staff serving the patients. In end of life care, is it more important for the patient’s pain to be managed or to treat an alcohol or drug problem? Is it unethical to “ignore” alcohol and drug use when someone may have only months to live?

- Some states have approved the use of medical marijuana; Ohio has not. It appears to be somewhat common or more “socially accepted” for some cancer patients to use marijuana in order to increase their appetites and decrease their nausea. If this is the case, how does this impact urine screens in pain facilities?

- Currently, most pain clinics access OARRS reports which display when and where a patient has obtained prescriptions. While this is accessible to physicians, is this information dealt with and addressed consistently? Is it mandatory for physicians to obtain this information and subsequently intervene? Will we ever see universal policy that creates guidelines for how pain clinics are to have positive urine screens on a consistent basis.
• What are the employee roles in each clinic? Are there in fact Social Workers, Chemical Dependency Counselors or other Psychosocial Services offered in each clinic? What is their role in intervening in patient care once a positive toxicology screen has been obtained.

• Perhaps a questionnaire could be developed to be completed by the physicians and psychosocial staff in a clinic to gain perspective into each of their roles in the clinic and their impression of what the other does. This could be beneficial in breaking down professional barriers and misconceptions.

• Track patients who work solely with just a pain management physician and are prescribed medications in comparison with those who work with a pain management physician and psychosocial team as well as being prescribed pain medications. With a longitudinal study, researchers could have clinics track the number of positive urine screens obtained over a period of three months to see what intervention, if any, was made and whether or not the patient remained a patient of the clinic. In addition, a more qualitative study would be beneficial in order to research, in more depth, the inner-workings of these facilities.

• Future studies should include larger sample sizes and should also be conducted in other areas of the country. It would also be interesting to see the difference in policy and procedures in clinics in states where medical marijuana is legal.
Policy Recommendations

As previously stated, it would be helpful to have a uniform policy regarding the handling of positive urine screens in addition to what is should be considered a positive urine screen. With the rising numbers of prescription drug use and diversion, it is time for a governing body to take action in order to halt these trends. With such variation in pain clinic policy and procedure, this enables patients to doctor shop. A database of patients being prescribed these large doses of medications should be kept to allow physician's to document patient compliance, those who have been discharged from a clinic and the reasoning behind such a decision. This would make other facilities aware of the problems that the patient has had in the past.

Practice Recommendations

As issues and concerns continue to arise regarding the abuse and misuse of pain medications in addition to using these medications and illegal substances, it will be and should be a priority to develop a program that can address this misuse and abuse while still treating the patients pain. It is puzzling that this hasn't been more of a priority up to this point. At the same time, while pain professionals should be aware of patients who struggle with this problem, labeling these patients as "complex patients" creates a stigma that is likely to follow these patients through any future medical care (similar to those who have struggled with an addiction in the past). Instead of avoiding treatment of this unique set of patients, through research and education, professionals must uncover best practice methods and interventions where patients are able to obtain the treatment that
they need and deserve as well as feeling comfortable maintaining open dialogue with their treatment professionals.
Chapter 7: Appendices

Appendix A

Recruitment Cover Letter

Dear Health Care Professional, 

We hope that this letter finds you well.

We are contacting you about an interesting and important research study that is being conducted by the College of Social Work at The Ohio State University. The purpose of the study is to explore the written and unwritten policies of pain clinics regarding positive toxicology screenings. We hope to learn about the different ways that pain clinics address this increasingly important issue.

The study consists of a brief survey. The survey should take about 5 minutes to complete. Please know that all of the information collected will be kept confidential and that identifying information will not be collected on participants or facilities. Erin Cruze, a graduate student in the College of Social Work, will be conducting the study under the guidance of Keith A. Anderson, PhD, Assistant Professor at The Ohio State University.

To encourage participation, we plan to donate $10 on behalf of each participating facility to the Ohio Pain Initiative, a non-profit group committed to education for health care professionals and the public on pain management.

If you have any questions regarding this survey, please contact the Dr. Anderson at anderson.1630@osu.edu or at 614.247-8963. For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251.

Thank you for your consideration. We hope to hear from you soon!

Sincerely,

Erin Cruze
Graduate Student
College of Social Work
The Ohio State University
Appendix B

Research Survey
“Toxicology Screening Procedures in Pain Clinics”
The Ohio State University

What is your position or title at the pain clinic? __________________________

How long have you worked at the pain clinic? _____ years and _____ months.

What are the primary types or causes of pain that you treat in the clinic?
☐ Cancer  ☐ Arthritis  ☐ Lumbar/Spinal  ☐ Other ______________________

How frequently are your patients given toxicology screenings?
☐ Initial Visit Only  ☐ Each Visit  ☐ Randomly  ☐ Based on Aberrances
☐ As Refill is Requested  ☐ Don’t Know  ☐ Other ______________________

What types of toxicology screenings do you use in the clinic?
☐ Immunoassays  ☐ Mass Spectrometry  ☐ GC/MS  ☐ LC/MS  ☐ Don’t Know
☐ Other ______________________

What does your clinic consider to be a positive toxicology screening?
☐ Alcohol  ☐ Illegal Drugs  ☐ Misuse of Prescription Drugs
☐ Absence of Prescribed Drugs  ☐ Don’t Know
☐ Other ______________________
What happens when a patient has a positive toxicology screening (such as discharging the patient at the first offense, discharge at second offense, offering counseling, referral for treatment, etc.):

Positive for Alcohol:
________________________________________________________________________
Positive for Illegal Drugs:
________________________________________________________________________
Positive for Misused Prescription Drugs:
________________________________________________________________________
Absence of Prescribed Drugs:
________________________________________________________________________

Are there standard procedures that the staff follow (please circle)? Yes No

Are these standard procedures from a written policy (please circle)? Yes No

If not from a written policy, how does the staff learn about these procedures related to positive toxicology screenings?
________________________________________________________________________
________________________________________________________________________

Do you have additional thoughts on this topic?
________________________________________________________________________
________________________________________________________________________

(please continue of other side).

Please mail the completed survey back to us in the attached envelope. Thanks again for your help!
Appendix C

Positive Urine Screen Interventions

The following list displays the responses obtained from the survey question inquiring about how a positive urine screen is handled.

- No more opioids after one positive screen, unless there are extenuating circumstances.
- No more medications until the patient can produce a clean screen.
- Continue to work with the patient unless prescribed medications by another facility (in that case they are dismissed).
- Physician speaks with the patient and will work with some; repeat problems are discharged; however the physician has the final say.
- If positive for marijuana the patient is referred to see the psychologist, if positive for cocaine the patient is immediately discharged, if there is an absence of prescription medications in the urine then a drug count is completed.
- The medications are stopped and some patients will continue to be under the care of the physician.
- The test is addressed with the patient, testing positive for cocaine or heroin warrants an immediate discharge and a referral to AOD treatment.
- Physician discretion.
- Address with the patient and they are given another chance.
- Stop opioids and counsel patient.
• If positive for alcohol the patient receives counseling, they are discharged with a positive cocaine test, and the whole picture is taken into consideration with prescription absence or misuse.

• If prescriptions are misused counseling is offered, the presence of illegal drugs or the absence of prescription medications leads to a discharge upon the patients second offense.

• Discharge at first offense.

• If alcohol is present the patient is counseled, illegal substances may cause the patient to be discharged or counseled depending on the type of drug, and the patient will not obtain any more medications if they are found to misuse or not use their prescription drugs.

• Alcohol use is not often a cause for discharge, illegal drugs along with absence or misuse of prescribed medications will lead to no more pain prescriptions and discharge.

• Dismissed and referred to psychologist for substance abuse or another pain provider.

• Continue to see the patient, but as a non-opioid patient.

• Patients using illegal drugs or are misusing their prescriptions are referred to chemical dependency treatment and weaned from their opioids. If there are no prescription drugs in their system, then they are discharged from the clinic.

• Those testing positive for alcohol are referred to counseling, all others will no longer obtain pain prescriptions.
• Those testing positive for alcohol are advised to stop, the physician decides how to handle those using illegal drugs or those misusing their prescriptions. When there is an absence of the prescribed medications in their system, a pill count is done. If there are pills missing that are not in the patients system they are discharged from the clinic.

• If marijuana is present, the patient is given two months and another chance to produce a clean urine. Those with illegal drugs in their system are discharged immediately; however those without their prescriptions in their system are often given another chance.

• Low risk, one time presence of illegal drugs or misuse/absence leads to counseling; however repeated positive screens receive an addictions evaluation and are terminated.

• Those using alcohol are counseled and given addictionologist information. Those using illegal drugs are to see an addictionologist, those misusing or not using their prescriptions no longer will receive services from the clinic and are not provided with a referral.

• The first offense requires counseling, the second offense leads to dismissal.

• Those using illegal substances are given a referral for a psychologist, all substance use results in immediate discharge, but are lenient of misuse.

• Illegal drug use leads to immediate discharge, misuse or absence of prescription drugs leads to researching the patients OARRS report, a discussion with the patient and they may get another chance.
• The patient is dismissed if they are not honest, but we are willing to work with them otherwise.

• Depends on the doctor, some are dismissed and others are given a second chance.

• Seven of the respondents reported an immediate discharge from the clinic.
Chapter 8: References


Violence and Injury Prevention Program, Bureau of Health Promotion and Risk Reduction, Office of Health Ohio, Ohio Department of Health, section 4, pg. 82.)


Results from the 2009 National Survey on Drug Use and Health (NSDUH): National Findings, SAMHSA (2010).

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