How to Handle “High-Maintenance” Patients

Patients with chronic headache or other pain conditions can be a challenge. Here’s how to better understand them and get your message across.

By Dawn C. Buse, PhD, Worcester, MA
The vast majority of patients who seek treatment for headache or other pain conditions will experience improvement and not become exceptional management challenges. However, a small subset of patients will be especially problematic and consume a great deal of time and resources for physicians as well as their staff. This article will provide an overview of some of the more common management challenges, behavioral “red flags,” and strategies to assist in treating these patients more effectively while reducing the frustration and stress that they can create for physicians and their staff.

Identifying Difficult Patients
Physicians can identify potentially difficult patients by being aware of behavioral red flags and potentially problematic comorbid conditions using interview techniques such as asking direct and open-ended questions, utilizing assessment instruments targeted toward identifying risk, observation of patients’ behavior, information from corroborating sources, and clinical intuition.

Experienced physicians will commonly experience an awareness that a patient may be difficult to treat or manage upon their first meeting. This “gut reaction” is likely based on previous experience with other challenging patients. It is wise to pay attention to and validate this response. When one has this feeling, he or she should consider further evaluation and institute a plan with clear boundaries and expectations immediately. Some pain and headache centers, hospitals and clinics have psychologists and psychiatrists on staff or easily available for consultation or referral.

For physicians who do not have easy access to mental health care professionals, there are many simple strategies which can be incorporated into a first visit and ongoing treatment in order to minimize future problems. Valuable data can be gathered through the clinical interview as well as through the use of empirically validated instruments which have been created for the purpose of identifying likely candidates for substance abuse, personality disorders, or other clinically significant factors. Physicians can also avoid or minimize problems by establishing clear and firm boundaries and guidelines from the onset of treatment. Suggestions for treatment contracts, expectations, consequences, and documentation will be provided.

Challenging Issues and Common “Red Flags”
Common correlates of management challenges include patients presenting with chronic, severe and intractable headaches (e.g., chronic daily headache), treatment refractory patients (i.e., patients who say they have already tried “everything” and seen “everyone”), a history of and/or current substance abuse, a history of criminal activity, and co-morbid conditions including but not limited to fibromyalgia, depression, traumatic brain injury and complex medical conditions. While each of these topics could be discussed at length, for the sake of brevity this article will focus on two of the most common and challenging issues: substance abuse and psychiatric comorbidities. However, many of the strategies discussed for the management of these issues can be easily adapted for the management of other challenging issues.

1. Psychiatric Issues. Psychological disorders can contribute to the intractability of migraine and headache and add difficulty to effective management. Research has shown that patients with comorbid psychiatric disorders are less likely to respond favorably to drug and behavioral therapies. Comorbid psychological diagnoses are also one of the best predictors of headache-related functional impairment, making it difficult to distinguish between impairment due to pain and impairment caused by psychological problems. It has also been demonstrated that psychological diagnoses play a more significant role in the transformation of migraine and the chronification of tension-type headaches than analgesic misuse.

Epidemiological studies show an association between migraine and anxiety, mood, and personality disorders (see Lake et al., 2005 for an excellent review of headache and psychiatric comorbidity). The relationships are complex and bidirectional. Depression and anxiety can play a role in precipitating or exacerbating headache or a migraine attack and the pain and disability that results from headache can lead to the onset or maintenance of a mood disorder. In the second case, the emotional distress may be reduced once the headache improves; however in cases of preexisting mood disorders, personality disorders,
Screening for Current or Potential Substance Abuse or Medication Misuse

While it has been established that individuals with a past history of substance abuse and addiction are at higher risk of having problems with opioid medications, it is possible to use existing screening tools and structured clinical management to provide effective treatment for their pain. Several screening tools are available to assess for potential for abuse of opioid medications. Two are described briefly below.

CAGE-AID Screen
The CAGE-AID is based on the CAGE questionnaire (Cut down, Annoyed, Guilt, and Eye-Opener) which was originally developed to screen for alcohol abuse. “AID” refers to “Adapted to Include Drugs.”17 The CAGE-AID is a brief screening tool which is used to assess for the risk of serious alcohol or drug problems. Questions include:

In the past, have you ever:
- (a) Felt that you wanted or needed to cut down on your drinking or drug use?
- (b) Been annoyed or angered by others’ complaining about your drinking or drug use?
- (c) Felt guilty about the consequences of your drinking or drug use?
- (d) Had a drink or taken a drug in the morning (eye-opener) to decrease hang-over or withdrawal symptoms?

A positive response to one CAGE-AID question suggests caution while two or more positive responses may reveal a significant current substance abuse problem and warrants referral to an addiction specialist for further evaluation and treatment. In this case a physician should be very cautious of prescribing potentially abusable medications and utilize the strategies described in the FSMB Guidelines.

The Screening Instrument for Substance Abuse Potential (SISAP)
The SISAP is a five-item screening screen that helps categorize patients into lower or higher risk of abusing prescribed opioids.18 This instrument is most effective when a patient’s history is well known and there is reliable supporting information available to validate his or her answers. A positive answer to any of the SISAP questions suggests the need for further assessment. The majority of patients will pass the screen and are probably at low risk of abusing opioids but clinical judgment is still required due to the obvious face validity of the instrument. This instrument has not been prospectively validated, but can be used to gain valuable data in making decisions about pharmacological treatment.

1. If you drink alcohol, how many drinks do you have on a typical day?
2. How many drinks do you have on a typical week?
3. Have you used marijuana or hashish in the past year?
4. Have you ever smoked cigarettes?
5. What is your age?

The authors of the SISAP recommend caution when prescribing opioids for the following patients:
1. Men who exceed four drinks per day or 16 drinks per week.
2. Women who exceed three drinks per day or 12 drinks per week.
3. A patient who admits to marijuana or hashish use in the past year. (It is recreational use of cannabis for euphoric effect that is of concern. The use of tetrahydrocannabinol derivatives to treat pain is controversial. Clinicians should exercise caution in recommending opioid therapy to a patient who is using cannabis regularly.)
4. A patient under 40 who uses nicotine.

Data gathered using one or more guided screening instruments should be combined with the physician’s clinical judgment, and in an ideal case, with other team members such as a psychologist, psychiatrist, or other team member who may help provide insight from a different vantage point to create the most informed and appropriate plan.

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and other psychiatric conditions successful management of the pain problem will most likely have a positive effect on the condition but will not “cure” the psychiatric disorder.

Since treatment outcome can be negatively influenced by psychiatric disorders, it is essential that the physician and/or multidisciplinary team screen patients for comorbid psychiatric issues. If the physician is working in a multidisciplinary setting it may be routine or possible for new patients to be screened by a psychologist or psychiatrist. However, if this type of consultation is not available, several screening instruments exist which can be useful in identifying comorbid psychological problems. Two examples include the Primary Care Evaluation of Mental Disorders,17 a brief instrument designed to screen for common psychiatric disorders seen in medical settings, and the Beck Depression Inventory; a 21-item paper and pencil screen which can be administered in the waiting room or sent home before an initial appointment to detect symptomology of depression.

Strategies to keep in mind in taking a history and conducting an initial interview include asking open ended instead of dichotomous questions and allowing for an interactional dialogue rather than a one-way interview. Patients may be uncomfortable admitting to psychiatric conditions and may consider conditions such as mood disorders a weakness. In addition, they may not understand the condition or actual diagnostic criteria.

For example, a man may think that since he does not cry he is not depressed; however, he may exhibit other criteria such as feeling asocial, anhedonic, experiencing difficulty with memory, concentration, and attention, feelings of hopeless about the future or worthless as a husband and father. These symptoms can be queried in a conversational manner or the patient may volunteer these symptoms on his own during a conversation. The diagnostic criteria for substance abuse, depression, anxiety, and personality disorders can all be queried in this manner.

This approach will provide richer information while also helping to establish a therapeutic alliance and facilitating the patient in feeling “listened to” and “cared about,” aspects which have been found to play a significant role in the patient’s confidence in the physician’s competency and quality of medical care.
Personality disorders are notoriously difficult to manage and can challenge the interpersonal skills of the physician and staff. Personality disorders can make treating a patient's headache much more difficult and unpleasant for the entire medical team. Migraine has been shown to occur in patients diagnosed with Borderline Personality Disorder (BPD) at a rate much higher than in the general population, in both men and women; therefore, it is imperative that the physician identify this disorder and employ effective techniques for dealing with the unpredictable displays of emotion and the manipulative, demanding behavior that may be encountered. Borderline Personality Disorder, perhaps the most well known and most difficult to manage of the personality disorders, is characterized by a pattern of unstable personal relationships, a poorly formed self-image and inadequate impulse control.

One of the hallmark behaviors and most challenging aspects of BPD is referred to as “splitting.” This term refers to the BPD patient’s tendency to use manipulative means to pit individuals against each other. The BPD patient also tends to see others as completely good or completely bad. In a medical office this may present as labeling one physician as “the worst physician ever” and another physician as “the best physician ever.” This categorization may shift from day to day, with someone being wonderful one day and terrible the next. The BPD patient may tell different staff members different pieces of information or report that one staff member said something that he or she did not to another staff member.

While these behaviors may seem very off-putting to others, the person suffering from BPD actually fears abandonment and will go to any length to prevent this, including self-harm or self-mutilation such as cutting and suicide attempts or parasuicidal gestures. Their mood may be very prone to outside stress, with feelings of depression, anxiety, and anger easily provoked. Under extreme stress, the BPD patient may experience paranoid ideation or dissociative symptoms.

All patients with BPD should have both a psychiatrist and a psychologist involved in their care. The gold standard of treatment for BPD is a comprehensive individual and group psychotherapeutic and educational approach called Dialectical Behavior Therapy and Cognitive Behavioral Therapy (see www.aabt.org for more information). Selective serotonin reuptake inhibitors may help with depression and impulse control and mood stabilizers can help moderate mood swings and irritability. A neurologist managing headache in an individual with BPD should work closely with the individual’s psychiatrist and psychologist, and if the patient does not have mental health care providers the physician should require that the patient get psychological treatment as a condition of treatment. The neurologist should also employ very careful and systematic boundary setting, treatment contracts, and documentation with these patients. The guidelines outlined for the management of individuals with substance abuse below can be applied to management of the BPD patient including agreement on treatment goals, setting strong and clear boundaries with specific consequences, and clear expectations for appropriate behavior (e.g., plans in the case of a suicide attempt, times and hours that the patient may call, limitations on behaviors towards office staff).

2. Substance Abuse. Substance abuse may include both prescription misuse and illicit or recreational substance abuse and may occur to different degrees of severity or risk. For example, a patient may be currently abusing substances on a regular basis or the patient may be active in a recovery program such as Alcoholic’s Anonymous with a 20-year history of abstinence. Research yields a potential range of three to 19 percent of chronic pain patients who meet criteria for abuse, dependence, or addiction to opioids although this is difficult statistic to measure precisely due to the considerable diversity in patient samples, variances in definitions and diagnoses, and variability in methods of analysis. The high potential for abuse and diversion of opioid medications can create significant concern for physicians. Fudin et al. opined that physicians commonly experience multiple concerns including apprehension about "opening the door" to abuse, incurring regulatory or legal action, inducing respiratory depression in vulnerable patients, and contributing to a substance abuse problem. However, an active substance abuse problem does not negative the need for pain control. In fact, Weaver and Schnoll note that undertreatment of pain in patients with substance abuse histories is more likely than adequate treatment to lead to drug-seeking behavior in recovering addicts.

An active substance abuse problem must be addressed for the treatment of headache or migraine to be successful. A current substance abuse problem presents many challenges to effective...
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treatment, including but not limited to, drug interaction, treatment noncompliance, medication misuse and many other problematic behaviors. The decision to prescribe narcotic and other potentially addictive medications should involve the physician’s clinical judgment, collateral input from multidisciplinary team members including mental health care professionals whenever possible, information from corroborating sources such as family members and other health care providers, and data from empirically validated assessment instruments which have been designed to aid in this process.

Successful treatment and management of patients with substance abuse diagnoses or high risk is a multi-step process. Each step should be clearly documented. A thorough and structured interview should be employed with all patients who may potentially receive opioid therapy with a focus on past or current substance use, abuse, and treatment. An initial interview should also assess for other psychiatric comorbidities, such as mood disorders or personality disorders as discussed above, as well as any history of legal, employment, and financial history, which may yield valuable data. Terms of treatment should be clearly outlined and expectations regarding behavior, limits, consequences, and stipulations should be clearly outlined and agreed upon at the outset. A behavioral or opioid contract can be useful in establishing this agreement. (See Fishman & Kreis, 2002 for a discussion of treatment contracts.)

Ongoing treatment should include periodic review and assessment which may include toxicology screens, and modifications of the treatment plan and contract as needed. Any violations of the treatment contract must be addressed immediately and the consequences followed through without exception. The United States Federation of State Medical Boards (FSMB) has issued guidelines designed to guide physicians in safely managing pain patients with a past, current, or high risk potential for substance abuse. They also provide an excellent glossary of terms related to substance abuse. The entire document is available at: www.medsch.wisc.edu/painpolicy/domaestic/model.htm.

While prescribing or dispensing chronic opioids, it is essential that particular attention is paid to the assessment of a patient’s clinical outcomes such as degree of pain relief, level of psychosocial and physical functioning, extent of medication side effects, and the presence of potentially problematic substance use behavior. In addition, the physician and treatment team should be aware of potential behavioral warning signs which may include:

- The patient frequently runs out of medication early.
- The patient reports medication lost, stolen, or ruined, resulting in requests for unscheduled refills.
- The patient cancels or does not show to scheduled appointments.
- The patient is “multisourcing,” (i.e., receiving medications from more than one physician or using the emergency room frequently for medications).

- The patient combines medication with alcohol or with other illicit or recreational substances.
- The patient’s level of medication-related functional impairment is increasing or has become problematic (e.g., vocational performance, inability to care for children, do household chores, operate a motor vehicle safely).
- The patient exhibits preoccupation with medication during office visits.
- The patient objects to or displays excessive emotional reactivity to the suggestion of dose reduction.
- The patient refuses or is very negative towards nonpharmacological treatments or modalities such as biofeedback, relaxation training, physical therapy, heat or cold.
- The patient refuses or is very negative towards meeting with a psychologist or psychiatrist.
- Family members express concern over the patient’s drug use.
- The patient refuses a drug or toxicology screen.

Other behaviors may be considered grounds for immediate termination of treatment and discharge, such as the discovery of falsified or altered prescriptions or a toxicology screen positive for non-prescribed or recreational drugs. These guidelines along with the course of action that will be taken should be explicitly stated in the treatment contract at the beginning of treatment. If, after enforcement of the consequences, instatement of additional safeguards and education, the patient continues to be non-compliant, it may be necessary to consider discharge. In this case a thorough evaluation on the part of all treating parties involved should be initiated and the outcome should be discussed with the patient and, with his consent, his spouse or family if appropriate.

All members of the treatment team including administrators should be involved in this process, which should include a thorough discussion about the ethical and legal implications of such a decision and follow up with the patient as to the rationale for discharge or termination, as well as the medically responsible and appropriate clinical course of action. In an outpatient setting, this might involve provision of appropriate and sufficient medication to initiate a reasonable taper so as to prevent a patient from experiencing withdrawal. Another option is to mandate participation in a substance abuse program either concurrent with treatment or before treatment will be resumed.

Some patients may present with a history of substance abuse from which they have been abstinent for a sufficient length of time or they may be actively involved in a recovery program such as Alcoholics Anonymous. A past history of alcoholism or other drug abuse does not automatically indicate that a patient will become a management problem, nor does such a history
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Model Guidelines for the Use of Controlled Substances for the Treatment of Pain

1. Evaluation of the Patient:
A complete medical history and physical examination must be conducted and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record should also document the presence of one or more recognized medical indications for the use of a controlled substance.

2. Treatment Plan:
The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

3. Informed Consent and Agreement for Treatment:
The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient, or with the patient’s surrogate or guardian if the patient is incompetent. The patient should receive prescriptions from one physician and one pharmacy where possible. If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician may employ the use of a written agreement between physician and patient outlining patient responsibilities including: (1) urine/serum medication levels screening when requested, (2) number and frequency of all prescription refills, and (3) reasons for which drug therapy may be discontinued (i.e. violation of agreement).

4. Periodic Review:
At reasonable intervals based upon the individual circumstance of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician’s evaluation of progress toward stated treatment objectives such as improvement in patient’s pain intensity and improved physical and/or psychosocial function, such as ability to work, need of health care resources, activities of daily living, and quality of social life. If treatment goals are not being achieved, despite medication adjustments, the physician should re-evaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans.

5. Consultation and Referral:
The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation, and consultation with or referral to an expert in the management of such patients.

6. Medical Records:
The physician should keep accurate and complete records to include: (1) the medical history and physical examination, (2) diagnostic, therapeutic and laboratory results, (3) evaluations and consultations, (4) treatment objectives, (5) discussion of risks and benefits, (6) treatments (7) medications (including date, type, dosage, and quantity prescribed), (8) instructions and agreements, and (9) periodic reviews. Records should remain current and be maintained in an accessible manner and readily available for review.

7. Compliance with Controlled Substances Laws and Regulations:
To prescribe, dispense, or administer controlled substances, the physician must be licensed in the state, and comply with applicable federal and state regulations. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and (any relevant documents issued by the state medical board) for specific rules governing controlled substances as well as applicable state regulations.

Source: United States Federation of State Medical Boards.
preclude treatment with potentially abusable medications. In fact, patients in recovery who are committed to staying “sober” may be especially vigilant about monitoring their medication use and may request non-narcotic and/or non-pharmacological approaches to treatment. This situation would provide the physician with an opportunity to educate patients about the difference between appropriate medical use and abuse, physical versus emotional dependence, and differences in risk of abuse for different classes of medication.

The Liaison Committee on Pain and Addiction, which was a collaborative effort of the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine, developed definitions related to the use of medications for the treatment of pain that are consistent with current understanding of relevant neurobiology, pharmacology and appropriate clinical practice. These definitions may be helpful in aiding patients in understanding the differences between tolerance, dependence and addiction. The definitions are available at www.ampainsoc.org/advocacy/opioids2.htm. This is also an excellent opportunity to collaborate with a pain psychologist to teach bio-behavioral approaches to pain management. (See Penzien & Rains, 2005 for a review of behavioral treatments to augment medical care of headache.)

Opioid therapy with previous substance abusers should follow the recommendations outlined in the FSMB Guidelines including education, a carefully detailed treatment plan, discussion of all expectations (e.g., pill counts at visits, random urine toxicology screens), consequences for noncompliance, and, with the patient’s informed consent, the involvement of family and significant others in the patient’s life (e.g., sponsor, friends) to inform them of the treatment plan to reduce the potential for stigmatization in relation to noncompliance and to engender necessary support. Unfortunately, in some cases all of these precautions may not be sufficient to prevent deviant substance use or relapse. The response of the treatment team including the possible decision to discharge the patient should be clear in establishing realistic and achievable goals for treatment. Setting realistic and achievable goals for treatment. For many headache, migraine and pain conditions, management of pain and improvement in quality of life is a more realistic goal than elimination of pain. Specific goals may include improving ability to cope with pain; teaching a variety of non-medication-based pain control modalities; increasing physical strength, endurance, and cardiovascular fitness; increasing mobility, independence, and functional activity; improving sleep; teaching proper body mechanics; increasing social and recreational activity; improving mood, improving cognitive functioning; decreasing and/or eliminating the patient’s dependence on narcotics or other medications; decreasing the patient’s over-utilization of the health care system; improving the patient’s psychological and emotional well-being; enhancing the patient’s vocational potential; providing vocational rehabilitation and facilitating return to work, volunteer work, and hobbies if/when appropriate; and enhancing family functioning and communication. It may be useful to ask about pain on a 0 to 10 point scale and recognize reductions in two points or more as positive gains. It can also be useful to have patients maintain daily headache diaries and note increase in headache free days or reduction in frequency of headache as a success.

Patients should be given reasonable expectations about the effect that medication can have on their condition as well as the aspects that they have control over, including lifestyle and behavior modifications. They should be counseled that medica-
Evaluating patients about lifestyle modifications they have control over can increase self-efficacy, compliance and motivation, and reduce depression.

Summary
The most effective way to manage challenging patients, both for their quality of care as well as the well being of the physician and staff treating them, is through a structured program of clinical care, including explicit treatment agreements and expectations, regular review, and careful documentation. The key elements to this approach include using a thorough and structured interview which should carefully assess substance abuse and psychiatric comorbidities, as well as any history of legal, employment, and financial history. Terms of treatment should be clearly outlined and expectations regarding behavior, stipulations, and consequences should be clearly discussed and agreed upon at the outset of treatment. Discussion should include the patient and physician as well as other members of the team and, with the patient’s informed consent, the patient’s spouse, family, or other significant persons in the patient’s life. Ongoing treatment should include regular assessment and modifications of the treatment plan and contract as needed. Any violations of the contract must be addressed immediately and the consequences followed through without exception.

If, after enforcement of the consequences, instatement of additional safeguards, reeducation, and stipulations such as participating in substance abuse treatment or referral to a mental health care provider a patient continues to be non-compliant discharge may be considered. This decision should include careful consideration of the ethical and legal implications. The patient, and if appropriate, his or her spouse or other family member should be involved in a discussion of the rationale for discharge and the medical follow-up plan. Regular communication between all involved staff about a patient’s case is useful to minimize any manipulative behaviors as well as providing support and creating a feeling of a “team.”

Regular communication with the patient’s other medical providers, especially mental health care providers, can also provide valuable information, minimize misinformation, and ensure that everyone is working together towards common goals in the best interest of the patient. The United States Federation of State Medical Boards Guidelines outline the necessary components for comprehensive evaluation, treatment planning, ongoing monitoring, limit and boundary setting and documentation. The steps that they outline are also useful and applicable to the successful management of patients with other issues such as mood or personality disorders. PN