The Long and Short of It

By: Dan Birch, OHS Canada
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Prescription narcotic use, perhaps abuse, has served as fodder for its fair share of headlines and has grabbed attention from medical and compensation types alike.

Ontario's Workplace Safety and Insurance Board (WSIB) in Toronto joined this group with the release of its "multifaceted" narcotics strategy, effective February 16, which seeks to head off the potential for addiction among claimants.

Components of the WSIB's new strategy include maximum doses, increased contact between community and board physicians to facilitate worker care, and discussions with health care providers regarding resources to help workers who have developed a dependence on narcotics, says WSIB spokesperson Christine Arnott.

Using prescription opioids - synthetic pain-killing drugs such as codeine, morphine and oxycodone - to ease chronic non-cancer pain (CNCP) is "controversial because of the side effects of opioids, the physical tolerance they build up (with related withdrawal reactions and possibility of addiction) and... disapproval by regulatory bodies," writes Dr. Andrea Furlan, co-author of a 2006 article in the *Canadian Medical Association Journal*. Nausea, vertigo and drowsiness are among the side effects, the review notes.

A key feature of the WSIB policy is the restricted use of long-acting opioids (LAO). Many workers with new injury claims will no longer be covered for LAOs during the first 12 weeks following an injury (claimants can use doctor-prescribed LAOs, but costs will not be paid by the WSIB), Arnott reports. Using short-acting opioids (SAO) is still permissible, she adds.

"The WSIB is concerned about the increasing risk of dependency observed with long-acting narcotics," says Arnott. "There are milder drugs on WSIB formularies available to workers which could be effective."

There are exemptions - the LAO prohibition does not apply to claimants with occupational diseases, such as cancer, or those in the WSIB's serious injury program.

MATTER OF DURATION

One difference between short- and long-acting narcotics is as their names suggest: duration. While the former is expected to relieve pain for two to four hours, pain relief with the latter is longer and it may only need to be taken once or twice daily, says Dr.

Janet Wright, an assistant registrar with the College of Physicians and Surgeons of Alberta in Edmonton.

The organization, working with regulatory colleges across the country, has created a national guideline for opioid use. It answers important questions for physicians, including the following: What factors should be considered when prescribing? How should addiction/outcomes be monitored? What steps should be taken if addiction appears to be forming?

Short and long versions of the same strength, Arnott notes, "may be equally effective. However, [SAOs] work faster and may be easier to adjust in dosing."

Management of prescription narcotics is an area that workers' compensation boards continue to evaluate as the evidence grows, says Jennifer Leyen, director of special care services at WorkSafeBC in Richmond, British Columbia.

For years, says WorkSafeBC chief medical officer Dr. Peter Rothfels, the board covered opioid costs only during the first eight weeks of recovery, barring "extenuating circumstances." The problem was that with no firm definition of "extenuating circumstances," it was interpreted in many ways, Dr. Rothfels says.

He suggests that some doctors were actually contributing to patients developing addictions. Despite best intentions, a physician would prescribe higher doses of opioids in a bid to ease a worker's pain, in some cases leading to addiction. "We felt we had to put the brakes on this."

WorkSafeBC instituted a practice directive in October of 2008 requiring that a review be done at the eight-week mark; the treating physician must fill out a form and provide information about the worker's health condition, narcotics treatment history and the effectiveness to date.

The claimant is also informed that he must agree to certain conditions, including that he will not sell the opioids, will use one doctor and one pharmacy, and will not obtain early refills, Dr. Rothfels notes. This establishes a contract and allows WorkSafeBC to opt out of payment if the worker does not meet the conditions, he adds.

The physician and worker letters must be returned to the board within four weeks, during which time the claimant's opioid expenses will be covered.

A WorkSafeBC medical advisor reviews cases where both the doctor and claimant request continuation of narcotics after eight weeks. If the advisor concurs, the treatment can go on for another three months; if the advisor disagrees, he will discuss the matter with the attending physician.

Should a decision be made to stop coverage at 12 weeks, Dr. Rothfels reports that WorkSafeBC offers additional pain management and addiction treatment services. "We are not impinging upon the physician's right to prescribe," he says. "We are simply saying we're not going to pay for it."

In Ontario, WSIB clinical staff carry out a review at the 12-week mark. WorkSafeBC, for its part, does not distinguish between long- and short-acting narcotics in its policies, Dr. Rothfels says. In as much as 90 per cent of cases, he notes, SAOs are prescribed in the first eight to 12 weeks post-injury/surgery.

He argues that most research shows the odds of developing an addiction are higher with SAOs than LAOs. Still, there are numerous individual factors that come into play.

In announcing its narcotics strategy, the WSIB highlighted some notable statistics: "Trends show that 40 per cent more injured workers have been prescribed narcotics (opioids) compared to 10 years ago. There have also been 100 per cent more narcotic prescriptions over that same time." But not only are more people receiving narcotics, the board notes, "doses prescribed by physicians have also increased."

Describing one of the motivations behind penning national guidelines, Dr. Wright of the Alberta college says it is hoped that they will help increase the comfort and confidence of physicians to prescribe painkillers.

In general, Dr. Wright says, doctors "are not trained very well in this area." This lack of experience can lead to doctors being hesitant to prescribe opioids in *bona fide* cases, meaning that some patients may not be getting the pain relief they need, she says. "How do we help people use these drugs, which can be very useful in the management of CNCP?"

The expectation is that that question will be answered with the national guideline, which will, ultimately, be made available online.

DIVIDED SUPPORT

What do injured worker advocates think of the WSIB's strategy? Steve Mantis, secretary for the Ontario Network of Injured Workers Groups, says he worries that it is "impinging" on the independence of doctors and, as such, may lead to claimants not receiving adequate pain relief.

The driving motivation may be more financial than health-related, suggests Mantis from his home near Thunder Bay, Ontario. Indeed, pointing to the WSIB's 2009 stakeholder consultation report, he says it cites the restricted narcotic formulary as a way to manage health care costs.

But the policy is aimed at ensuring "injured workers obtain appropriate narcotic therapy as prescribed by their physicians to support treatment goals, including recovery and safe return to work," Arnott responds. "Since the WSIB offers alternative drugs to long-acting narcotics for pain control, there may be little impact on overall drug costs."

At WorkSafeBC, Dr. Rothfels notes "the motivation was the human cost, particularly around what happens to injured workers on long-term, and particularly high-dose, narcotics. We see terrible spirals that happen to them."

Arnott says that in cases where a treating physician feels strongly that an LAO is necessary, "case-specific circumstances will always be considered."

Mantis says he would like to see some analysis of how many injured workers are taking painkillers, why they need this type of medication and what the outcomes have been. "If the worker's health is the number one priority, let's have some information," he argues.

Mantis suggests opioid-linked side effects can negatively affect the safety of a worker (or of co-workers) on the job.

WorkSafeBC's Leyen says responses such as drowsiness could prove dangerous in certain situations, including when a heavy equipment operator requires a high level of cognitive awareness and manual dexterity to complete work tasks. She emphasizes, however, that every client has "a different response to the narcotics."

Dr. Wright notes that side effects typically appear when opioid therapy begins and when dosage is increased.

The issue of opioid-using injured workers has surfaced in Saskatchewan, where some worker advocates have argued that the compensation board's return-to-work (RTW) policies force some claimants to return too early, possibly endangering their own lives and those of co-workers.

Injured workers may conceal their painkiller use, says Ellen MacEachen, Ph.D., a scientist at the Institute for Work & Health in Toronto. Dr. MacEachen, who has undertaken research into problematic RTW cases, cites the example of a miner operating heavy machinery who does not want to complain because he does not want to lose his job.

Dr. MacEachen and her team surveyed 48 injured workers in Ontario who were having great difficulty with the RTW process. Unprompted, 20 workers mentioned opioid use specifically and 21 spoke of medications generally.

"They take the pain medication to cope with the requirement of going back early," suggests Dr. MacEachen. Doing so, however, leads to the twin risks of overexertion/re-injury or injury resulting from impairment, she says.

Mantis points to the peer pressure "to pick up your end of the work. You take another pill and you do [the work], but that ends up in further injury or re-injury."

KEEPING TRACK

Ellen MacEachen, Ph.D., a scientist at the Institute for Work & Health in Toronto, says that more attention needs to be paid to the relationship between early return-to-work (RTW) conditions and prescription narcotic use by injured workers. "The worker is the one at the centre, sort of in this grey zone," Dr. MacEachen suggests.

In light of her research, she makes the following observations:

Improved communication about RTW problems is needed;

Workers and doctors are the key parties in recognizing medication use and RTW difficulties, meaning safe forums for worker feedback about workplace conditions are necessary and physician advice should be taken seriously; and,

To ensure proper monitoring, employers should know what type of medications are being used, workers' compensation board decision-makers should track medication use, and when medication use is high, board decision-makers should consider problems in workplace conditions, not just worker coping strategies.

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