Are there any current treatment guidelines or recommendations regarding management of patients who score high on the Opioid Risk Tool and still require opioid treatment?

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Numerous guidelines have been published regarding appropriate use of opioids in acute, subacute, and chronic non-cancer pain (CNCP).[1-8] As abuse, misuse, and serious adverse events related to opioids have increased, various measures and tools have been developed to assess the risk for opioid addiction. The Opioid Risk Tool [5] is a short, validated screening questionnaire used in primary care settings to assess a patient's risk for opioid abuse.[9,10] Patients classified as high-risk are considered to be at a higher risk for abusive behavior; risks include family or personal history of substance abuse (alcohol, illegal drugs, prescription drugs) age between 16 – 45 years, history of preadolescent sexual abuse, and psychological disease (attention deficit-hyperactivity disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia, or depression). Based on this, guidelines for opioid prescribing were reviewed to determine how high-risk patients requiring opioid treatment should be managed. Table 1 provides a summary of guideline recommendations for use of opioids in high-risk patients.

Table 1: Guideline recommended treatment for high-risk patients.[1-8]

Guideline	Recommendations
ACOEM (2014)[6]	-Considerable caution is recommended for use of opioids in patients with risk factors (psychiatric disorders, substance abuse history, alcohol use) due to risk for adverse events, overdose, and death -Comprehensive history/physical exam, informed consent, treatment agreements, drug screening, and attempts at tapering are recommended -Acute pain: opioids are not recommended unless other agents such as NSAIDs have failed; use lowest effective dose of SAO (as needed dosing preferred); use adjunctively with NSAID/APAP; LAOs not recommended; taper after 1-2 weeks -Subacute (1-3 months) and CNCP (>3 months): opioids should only be used after failure of other evidence-based approaches to improve function; UDTs are recommended at baseline and randomly at least 2-4 times/year; additional monitoring for high-risk patients is not addressed
NYC DOH (2013)[4]	-Note: guideline focused on ED discharge opioid prescribing -Recommends use of validated screening tools to assess for abuse/misuse; states that a history of a substance use disorder should not exclude patients from receiving an opioid for acute pain; recommends referral for treatment of dependence/addiction -Does not address how high-risk patients should be managed
ASIPP (2012)[7,8]	-Cites APS guidelines (see below) for treatment of high-risk patients -Monitoring of high-risk patients: UDTs every 3-6 months; PMP 4 times/year; avoid opioid or use low doses (10 mg MED); avoid dose escalations; rarely use >50 mg MED; patients displaying aberrant behaviors should be weaned off

Guideline	Recommendations
SAMHSA TIP 54 (2012)[3]	-Patients with active opioid addiction and CNCP: initiate addiction treatment; defer opioids/analgesia or initiate a trial of opioid weaning; continue opioids only if patient initiates substance abuse treatment -Patients in recovery: continue opioid if currently receiving or initiate non-opioid treatment; recommends non-pharmacologic treatments (CBT, exercise, etc.), reconditioning based on functional impairment; treatment of psychiatric/sleep conditions; only initiate opioid if potential benefit outweighs risk; continue only as long as beneficial -Initiate an opioid with minimal rewarding properties such as codeine or tramadol; avoid high doses; if high potency opioids are needed, use a slow-onset/prolonged duration agent; avoid agents that are injected or are easily converted to forms that are abused - Comprehensive history/physical exam, informed consent, written opioid treatment agreements, education of patients/family regarding treatment options/goals/outcomes are recommended -Monitoring: regular visit intervals (high-risk patients may require weekly visits), documentation of treatment details and results; reassessment of pain scores/level of function. Prescribers should control the medication supply (e.g., prescriptions with small quantities, use of pill counts), and conduct UDTs -Complicated cases may benefit from a team approach (addiction specialist, PCP, pharmacist, etc.)
Washington State Interagency (2010)[2]	-High-risk patients may receive opioids, but require additional monitoring: frequent reassessment of pain, function, aberrant behaviors; decreasing the number of doses prescribed; increased frequency of UDTs (up to 3-4/year)
VA/DoD (2010)[1]	-High-risk patients: initiate trial of an as-needed opioid with frequent monitoring and follow-up; consider consultation with a specialist for patients with psychiatric disorders, receiving treatment for a substance abuse disorder -All patients should receive informed consent, opioid treatment agreement, documentation of treatment plan, and follow-up -Difficult patients: refer to an addiction or pain specialist

Guideline	Recommendations
APS (2009)[5]	-Evidence lacking regarding best way to manage high-risk patients -May consider opioid treatment for high-risk patients (history of drug abuse, psychiatric issues, serious aberrant drug-related behaviors) with CNCP if stringent and frequent monitoring is implemented -Monitoring of high-risk patients includes: weekly documentation of pain intensity, level of functioning, progress toward treatment goals, adverse events, adherence -UDTs are recommended (evidence lacking regarding frequency of monitoring, but random testing may be appropriate) -May also consider pill counts, family member/caregiver interviews -Patients actively using illicit drugs: only prescribe in a highly-controlled/specialized setting such as an opioid treatment program with direct observation. Other methods include limiting quantities and requiring authorization -Strongly consider consultation with a mental health or addiction specialist

ACOEM=American College of Occupational and Environmental Medicine; APAP=acetaminophen; APS=American Pain Society; ASIPP=American Society of Interventional Pain Physicians; CBT=cognitive behavioral therapy; CNCP=chronic non-cancer pain; DOH=Department of Health; ED=emergency department; LAO=long-acting opioid; MED=morphine equivalent dose; NSAID=non-steroidal anti-inflammatory drug; NYC=New York City; PCP=primary care provider; PMP=prescription monitoring program; SAMHSA=Substance Abuse and Mental Health Services Administration; SAO=short-acting opioid; TIP=Treatment Improvement Protocols; UDT=urinary drug test; VA/DoD=Department of Veterans Affairs & Department of Defense

In summary, the reviewed guidelines recommend that patients who are classified as high-risk may be considered for opioid treatment after careful evaluation.[1-8] Important measures to conduct or implement prior to initiating opioid treatment include performing a comprehensive history/physical examination, obtaining informed consent, institution of an opioid treatment agreement, and patient/family education regarding treatment goals, options, and outcomes. Frequent monitoring and follow-up are also essential for high-risk patients and should include regular office visits (as frequently as weekly), documentation of treatment, reassessment of pain scores/level of function, and urinary drug tests. Other tools include controlling the medication supply (prescribing small quantities),[2,3] pill counts,[3,5] family/caregiver interviews,[3,5] trial with an as-needed short-acting opioid,[1] use of low doses (10 mg morphine equivalent dose),[5,7,8] use of minimal-rewarding opioids (codeine, tramadol),[3] avoidance of dose escalation/high doses/injectable products,[3,5,7,8] use of slow-onset/prolonged duration agents if high potency opioids are needed,[3] attempts at opioid tapering,[6] and adjunctive use of non-steroidal anti-inflammatory agents or acetaminophen.[6] In addition, prescribers should consider referring complicated patients, including those with active addiction, to pain and/or addiction specialists.[1,3,4]

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