Guide to Aberrant Drug-Related Behavior When Prescribing Opioids for Pain Management

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<table>
<thead>
<tr>
<th>Honorarium: Consultant</th>
<th>Honorarium: Advisory Board</th>
<th>Travel Expenses</th>
</tr>
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<tbody>
<tr>
<td>Acura Pharmaceuticals</td>
<td>Depomed</td>
<td>Acura Pharmaceuticals</td>
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<tr>
<td>AstraZeneca</td>
<td>Egalet</td>
<td>AstraZeneca</td>
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<td>BioDelivery Sciences International</td>
<td>Inspirion Pharmaceuticals</td>
<td>BioDelivery Sciences International</td>
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<tr>
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<td>Insys Therapeutics</td>
<td>Bristol-Myers Squib (BMS)</td>
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<tr>
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<td>Kaleo</td>
<td>Grunenthal USA</td>
</tr>
<tr>
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<td>Mallinckrodt Pharmaceuticals</td>
<td>Inspirion Pharmaceuticals</td>
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<td>Signature Therapeutics</td>
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<td>Jazz Pharmaceuticals</td>
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<td>Nevro Corporation</td>
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<td>Teva Pharmaceuticals</td>
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<td>Travena</td>
</tr>
</tbody>
</table>

- This presentation does not contain off-label or investigational use of drugs or products
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American Academy of Pain Medicine
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PharmaCom Group
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Target Audience

• The overarching goal of PCSS-O is to offer evidence-based trainings on the safe & effective prescribing of opioid medications in the treatment of pain &/or opioid addiction.

• Our focus is to reach providers &/or providers-in-training from diverse healthcare professions including physicians, nurses, dentists, physician assistants, pharmacists, & program administrators.
Educational Objectives

- At the conclusion of this activity participants should be able to:
  1. Understand how to assess for & interpret aberrant drug-related behaviors
  2. Devise a plan to incorporate common risk assessment tools into clinical practice
  3. Utilize information from risk assessment in order to stratify patients’ risk
## Definition of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Misuse</strong></td>
<td>Use of a medication (for a medical purpose) other than as directed or as indicated, whether willful or unintentional, &amp; whether harm results or not</td>
</tr>
<tr>
<td><strong>Abuse</strong></td>
<td>Any use of an illegal drug&lt;br&gt;The intentional self administration of a medication for a non-medical purpose, such as altering one’s state of consciousness, eg, getting high</td>
</tr>
<tr>
<td><strong>Diversion</strong></td>
<td>The intentional removal of a medication from legitimate distribution &amp; dispensing channels</td>
</tr>
<tr>
<td><strong>Addiction</strong></td>
<td>A primary, chronic, neurobiological disease, with genetic, psychosocial, &amp; environmental factors influencing its development &amp; manifestations&lt;br&gt;Behavioral characteristics include one or more of the following: Impaired control over drug use, compulsive use, continued use despite harm, craving</td>
</tr>
</tbody>
</table>

## Comparison of DSM-IV & DSM-5 Criteria for Opioid Use Disorder

<table>
<thead>
<tr>
<th>DSM-IV Abuse</th>
<th>DSM-IV Dependence</th>
<th>DSM-5 Opioid Use Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥1 criteria in 12-mo period*</td>
<td>≥3 criteria in 12-mo period</td>
<td>≥2 criteria in 12-mo period</td>
</tr>
<tr>
<td><strong>Recurrent use in physically hazardous situations</strong></td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td><strong>Social/interpersonal problems related to use</strong></td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td><strong>Neglected major roles at work, school, or home due to use</strong></td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td><strong>Recurrent substance-related legal problems</strong></td>
<td>✓</td>
<td>-</td>
</tr>
<tr>
<td><strong>Withdrawal</strong></td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Tolerance</strong></td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Used larger amounts or for longer than intended</strong></td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Desired or unsuccessful attempts to quit/control use</strong></td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Much time spent obtaining, using, or recovering</strong></td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Continued use despite physical/psychological problems</strong></td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Social/occupational/recreational activities given up/reduced due to use</strong></td>
<td>-</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Craving or a strong desire or urge to use opioids</strong></td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

*And no diagnosis of dependence

Severity of the disorder is based on the number of criteria endorsed:

- Mild: 2 to 3 criteria
- Moderate: 4-5 criteria
- Severe: ≥6 criteria

These 3 DSM-5 categories broadly correlate with:

- Misuse (mild)
- Abuse (moderate)
- Addiction (severe)
Who Misuses/Abuses Opioids & Why?

Non-Medical Use
- Recreational abusers
- Patients with the disease of addiction

Medical Use
- Pain patients seeking more pain relief
- Pain patients escaping emotional pain
Spectrum of Behaviors

SUD = substance-use disorder

Routes of Prescription Opioid Misuse/Abuse

- Most early misusers/abusers ingest them orally.
- As abuse progresses, users increasingly modify route of ingestion for a faster onset of action.
- Even among individuals admitted to substance abuse treatment, 58.5% reported oral use.

Amongst those entering substance abuse treatment:

- Oral: 58.5%
- Injected: 17.0%
- Inhaled: 20.7%
- Smoked: 2.8%
- Other: 1.0%

Major Opioid Risks

• Opioid use disorder
  ▪ Misuse
  ▪ Abuse
  ▪ Addiction
• Diversion
• Overdose
Significant Risk Factors for Abuse & Overdose

- Pharmacologic substance
  - Potency
  - $T_{max}$
  - $C_{max}$
  - Availability

- Patient risk factors
  - Individual risk factors
  - Environmental risk factors

- Prescriber behavior
  - Improper patient selection, dosing, & titration
  - Improper patient counseling & management
Problem

Total chronic pain population

ADRB (misuse) 40%

Abuse 20%

Addiction 2%-5%

ADRB = aberrant drug-related behavior

# Prevalence of Opioid Use Disorder Among Chronic Pain Patients

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Prevalence</th>
</tr>
</thead>
</table>
| Boscarino et al, 2011                      | 705  | • Lifetime opioid-use disorder as defined by DSM-5: 34.9% (21.7% moderate; 13.2% severe)  
• Lifetime opioid dependence as defined by DSM-IV: 35.5% |
| Noble et al, 2010                          | 4,893* | • Opioid use disorder†: 0.27%                                              |
| Fleming et al, 2007                        | 801  | • Opioid use disorder: 3.8%  
○ Past 30 days opioid dependence as defined by DSM-IV: 3.1%  
○ Past 30 days opioid abuse as defined by DSM-IV: 0.6% |
| Von Korff et al, 2011 (reference to Fleming et al, 2007 article) | 801  | • Purposeful over-sedation: 26%  
• Increasing dose without prescription: 39%  
• Obtaining extra opioids from other doctors: 8%  
• Use for purposes other than pain: 18%  
• Drinking alcohol to relieve pain: 20%  
• Hoarding pain medications: 12% |

*Meta-analysis of 26 studies that enrolled a total of 4893 participants
†As defined by each study

Aberrant Behaviors in Pain Patients With & Without Prescription Drug Use Disorder

Cumulative number of aberrant behaviors

Percent of patients

Minimum number of aberrant behaviors

PDUD
No Disorder

N=264

# Aberrant Behaviors Among Chronic Pain Patients

<table>
<thead>
<tr>
<th>Total number of aberrant behaviors reported</th>
<th>Percent of patients (N=388)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>55.4%</td>
</tr>
<tr>
<td>1 to 2</td>
<td>25.3%</td>
</tr>
<tr>
<td>3 to 4</td>
<td>8.5%</td>
</tr>
<tr>
<td>5 to 7</td>
<td>6.7%</td>
</tr>
<tr>
<td>≥8</td>
<td>4.1%</td>
</tr>
</tbody>
</table>

44.6% of respondents engaged in ≥1 behavior

Aberrant Behaviors in Patients with Cancer & AIDS-Related Pain

- AIDS patients reported a mean of 6.14 aberrant behaviors/patient
  - Compared with a mean of 1.42 behaviors/patient among cancer patients

# Patient Risk Factors for Aberrant Behaviors/Harm

<table>
<thead>
<tr>
<th>Biological</th>
<th>Psychiatric</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Age ≤45 years</td>
<td>• Substance use disorder</td>
<td>• Prior legal problems</td>
</tr>
<tr>
<td>• Gender</td>
<td>• Preadolescent sexual abuse (in women)</td>
<td>• History of motor vehicle accidents</td>
</tr>
<tr>
<td>• Family history of prescription drug or alcohol abuse</td>
<td>• Major psychiatric disorder (eg, personality disorder, anxiety or depressive disorder, bipolar disorder)</td>
<td>• Poor family support</td>
</tr>
<tr>
<td>• Cigarette smoking</td>
<td>• Depression</td>
<td>• Involvement in a problematic subculture</td>
</tr>
<tr>
<td>• Physical Illnesses</td>
<td></td>
<td>• Unemployed</td>
</tr>
<tr>
<td>• Pain severity</td>
<td></td>
<td>• Isolation</td>
</tr>
<tr>
<td>• Pain duration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sleep disorders</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Assessments of Aberrant Behaviors

- Urine drug testing
- Prescription-monitoring programs
- Predictive assessment tools
- Patterns of Use
- Family & friends
- Pharmacists

Assessment Tools

• Use prior to prescribing opioids
  ▪ Screener and Opioid Assessment for Patients in Pain (SOAPP)
  ▪ Opioid Risk Tool (ORT)
  ▪ Diagnosis, Intractability, Risk, Efficacy (DIRE)

• Use during prescribing of opioids
  ▪ Current Opioid Misuse Measure (COMM)

Limitations of Familiar Screening Tools

• Designed to identify patients who already have problems managing substance intake, *not* to predict who may develop problems
• *Not* designed to screen specifically for opioid abuse
• Often take a long time to administer & require unique skills to interpret

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:
0 = Never    1 = Seldom    2 = Sometimes     3 = Often    4 = Very Often

1. How often do you have mood swings? 0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4
3. How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? 0 1 2 3 4
5. How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

To score the SOAPP V.1.0-SF, add ratings of all questions:
A score of ≥4 is considered positive

<table>
<thead>
<tr>
<th>Sum of questions</th>
<th>SOAPP indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥4</td>
<td>+</td>
</tr>
<tr>
<td>&lt;4</td>
<td>-</td>
</tr>
</tbody>
</table>

SOAPP is available in 3 formats: 5Q, 14Q, & 24Q

Opioid Risk Tool (ORT)

Mark each box that applies

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family history of substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alcohol</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Illegal drugs</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Prescription drugs</td>
<td>4</td>
</tr>
<tr>
<td>2. Personal history of substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alcohol</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Illegal drugs</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Prescription drugs</td>
<td>5</td>
</tr>
<tr>
<td>3. Age (mark box if 16-45 years)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. History of preadolescent sexual abuse</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>5. Psychological disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>ADD, OCD, bipolar, schizophrenia</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>1</td>
</tr>
</tbody>
</table>

ADD = attention deficit disorder; OCD = obsessive-compulsive disorder

- Exhibits high degree of sensitivity & specificity
- 94% of low-risk patients did not display an aberrant behavior
- 91% of high-risk patients did display an aberrant behavior

<table>
<thead>
<tr>
<th>Total score</th>
<th>Risk</th>
<th>% with aberrant behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3</td>
<td>Low</td>
<td>6%</td>
</tr>
<tr>
<td>4-7</td>
<td>Moderate</td>
<td>28%</td>
</tr>
<tr>
<td>≥8</td>
<td>High</td>
<td>91%</td>
</tr>
</tbody>
</table>

N=185

Level of Abuse in Stressful Environments

Differential Diagnosis: Aberrant Drug-Taking Attitudes & Behavior

- Addiction
- Pain-relief seeking
- Pain-relief seeking & substance-use disorder
- Other psychiatric diagnosis
  - Organic mental syndrome
  - Personality disorder
  - Chemical coping
  - Depression/anxiety/situational stressors
- Criminal intent (diversion)

Aberrant Medication Taking Behaviors
Pain-Relief Seeking: Differential Diagnosis

- Disease progression
- Poorly opioid responsive pain
- Withdrawal mediated pain
- Opioid-induced hyperalgesia
- Opioid analgesic tolerance
Drug Seeking: Addiction

• A clinical syndrome presenting as…
  ▪ Loss of Control
  ▪ Compulsive use
  ▪ Continued use despite harm
  ▪ Craving

• Addiction is NOT the same as physical dependence
  ▪ Biological adaptation with signs & symptoms of withdrawal (eg, pain) if opioid is abruptly stopped

Behaviors Concerning for Addiction
The Spectrum: Yellow to Red Flags

- Requests for increased opioid dose
- Requests for specific opioid by name, “brand name only”
- Unsanctioned dose escalation or other noncompliance with therapy on 1 or 2 occasions
- Nonadherence with other recommended therapies (eg, physical therapy)
- Resistance to change therapy despite adverse effects (eg, over-sedation)
- Deterioration in function at home & work
- Multiple dose escalations or other noncompliance with therapy despite warnings
- Nonadherence with monitoring (eg, pill counts, urine drug testing)
- Multiple “lost” or “stolen” opioid prescriptions
- Illegal activities (eg, forging prescriptions, selling prescription opioids)
Discussing Possible Addiction

• Give specific & timely feedback why patient’s behaviors raise your concern for possible addiction, eg, loss of control, compulsive use, continued use despite harm
• Remember patients may suffer from both chronic pain & addiction
• May need to “agree to disagree” with the patient
• Benefits no longer outweighing risks
  ▪ “I cannot responsibly continue prescribing opioids as I feel it would cause you more harm than good”
• Always offer referral to addiction treatment
• Stay 100% in “Benefit/Risk” mindset
When to Refer to an Addiction Medicine Specialist

- When a patient:
  - Is using illicit drugs
  - Is experiencing problems with other prescription drugs
    - eg, benzodiazepines
  - Has an addiction or abuse to alcohol
  - Agrees they have an opioid addiction & wants help
  - Has a dual or a trio diagnosis of pain, addiction, & psychiatric disease
Diversion

• Drug diversion is defined as a supply of prescription medication intended for one person being given, bartered or sold to another
• Patients who have had medications stolen, lost, or otherwise taken unintentionally also qualify as participants in drug diversion

### Frequency & Type of Diversion Among a Pain Clinic Population

<table>
<thead>
<tr>
<th># of incidents</th>
<th>Sharing</th>
<th>Selling</th>
<th>Stolen</th>
<th>Lost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=340</td>
<td>n=336</td>
<td>n=338</td>
<td>n=342</td>
</tr>
<tr>
<td>0</td>
<td>304 (89.4%)</td>
<td>330 (98.2%)</td>
<td>238 (70.4%)</td>
<td>272 (80.0%)</td>
</tr>
<tr>
<td>1</td>
<td>16 (4.7%)</td>
<td>4 (1.2%)</td>
<td>54 (16.0%)</td>
<td>42 (12.3%)</td>
</tr>
<tr>
<td>2</td>
<td>4 (1.1%)</td>
<td>1 (0.3%)</td>
<td>26 (7.7%)</td>
<td>21 (6.1%)</td>
</tr>
<tr>
<td>3</td>
<td>5 (1.5%)</td>
<td>0</td>
<td>10 (3.0%)</td>
<td>5 (1.5%)</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>0</td>
<td>2 (0.6%)</td>
<td>1 (0.3%)</td>
</tr>
<tr>
<td>≥5</td>
<td>11 (3.2%)</td>
<td>1 (0.3%)</td>
<td>8 (2.4%)</td>
<td>1 (0.3%)</td>
</tr>
<tr>
<td>≥1</td>
<td>36 (10.6%)</td>
<td>6 (1.8%)</td>
<td>100 (29.6%)</td>
<td>70 (20.5%)</td>
</tr>
</tbody>
</table>

- Most common type of drug diversion was loss due to theft
  - 29.6% of respondents

# Frequency of Stolen Medications Per Age Group

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>How many times medications stolen (%)</th>
<th>% of responses ≥1</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24 (n=2)</td>
<td>2 (100.0%) 0 0 0 0 0</td>
<td>0%</td>
</tr>
<tr>
<td>25-34 (n=29)</td>
<td>19 (65.5%) 5 1 2 0 2</td>
<td>34.5%</td>
</tr>
<tr>
<td>35-44 (n=62)</td>
<td>38 (61.3%) 14 6 1 0 3</td>
<td>38.7%</td>
</tr>
<tr>
<td>45-54 (n=119)</td>
<td>76 (63.9%) 18 16 5 2 2</td>
<td>36.1%</td>
</tr>
<tr>
<td>&gt;55 (n=101)</td>
<td>81 (80.2%) 14 3 2 0 1</td>
<td>19.8%</td>
</tr>
<tr>
<td>Total (n=313)</td>
<td>216 51 26 10 2 8</td>
<td>31.0%</td>
</tr>
</tbody>
</table>

Frequency missing = 14

# Frequency of Stolen Medications Per Marital Status

<table>
<thead>
<tr>
<th>Marital status</th>
<th>How many times medications stolen (%)</th>
<th>% of responses ≥1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Never married</td>
<td>19</td>
<td>3</td>
</tr>
<tr>
<td>(n=28)</td>
<td>(67.9%)</td>
<td>(10.7%)</td>
</tr>
<tr>
<td>Divorced</td>
<td>39</td>
<td>12</td>
</tr>
<tr>
<td>(n=63)</td>
<td>(61.9%)</td>
<td>(19.0%)</td>
</tr>
<tr>
<td>Widowed</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>(n=11)</td>
<td>(63.6%)</td>
<td>(18.2%)</td>
</tr>
<tr>
<td>Married</td>
<td>148</td>
<td>33</td>
</tr>
<tr>
<td>(n=206)</td>
<td>(71.8%)</td>
<td>(16.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>213</td>
<td>50</td>
</tr>
<tr>
<td>(n=308)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency missing = 19</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Suicide

ED visits for drug-related suicide attempts (thousands)

- **All drugs**: 161.6, 151.6, 182.8, 197.1, 199.5, 198.4, 212.7, 228.4
- **Opioid analgesics**: 16.9, 17.8, 24.5, 29.9, 26.8, 29.6, 32.9, 31.7

- **41% increase in drug suicide attempts**
- **87% increase in opioid suicide attempts**

Why Suicide? Non-Pain Patients

Escape from severe suffering

Only option

Hopelessness

Permanent solution

Suicide Ideation in Chronic Pain Patients

- Hitchcock
  - 50% chronic pain patients had suicidal thoughts due to pain

- Fishbain
  - Pain severity
  - Severe comorbidity (depression)

## Risk for Suicide Among Pain Patients

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Family history of suicide</td>
<td>✓ History of substance abuse</td>
<td></td>
</tr>
<tr>
<td>✓ <strong>History of childhood abuse</strong></td>
<td>✓ Impulsive &amp; aggressive behaviors</td>
<td></td>
</tr>
<tr>
<td>✓ Previous suicide attempts</td>
<td>✓ Losses such as work, family, self-esteem</td>
<td></td>
</tr>
<tr>
<td>✓ History of mental disorder, particularly depression</td>
<td>✓ Isolation</td>
<td></td>
</tr>
<tr>
<td>✓ Hopelessness</td>
<td>✓ Physical illness</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>+1: Access to potentially lethal doses of prescription medications (ie, opioids)</td>
</tr>
</tbody>
</table>

Tang NK, Crane C. *Psychol Med*. 2006;36:575-86.
# Risk Stratification

<table>
<thead>
<tr>
<th>Lower Risk</th>
<th>Moderate Risk</th>
<th>Higher Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care patients</td>
<td>Primary care patients with specialist support</td>
<td>Pain specialist patients</td>
</tr>
</tbody>
</table>

### Lower Risk
- ORT Score 0-3
  - No past or current history of substance use disorders
  - No family history of past or current substance use disorders
  - No major or untreated psychopathology
  - Consistent UDT results
  - Consistent PDMP results
  - Mild to moderate pain

### Moderate Risk
- ORT Score 4-7
  - May be a past history of substance use disorders
  - May be a family history of problematic drug use
  - May have past or concurrent psychopathology
  - Not actively addicted
  - Usually consistent UDT results
  - Consistent PDMP results
  - Mild to severe pain

### Higher Risk
- ORT Score ≥8
  - Active substance use disorders
  - Major, untreated psychopathology
  - Poor social support
  - Actively addicted
  - Inconsistent UDT results
  - PDMP multiple prescribers
  - Moderate to severe pain

ORT = Opioid Risk Tool; PDMP = Prescription Drug Monitoring Program; UDT = urine drug testing

Conclusion

- Aberrant drug-related behaviors must be assessed
- Risk assessment can be easily implemented into most clinical practices
- Risk assessment leads to risk stratification
- Risk stratification can help match appropriate monitoring to mitigate abuse, potential diversion, suicide, & overdoses
References

- Tang NK, Crane C. Psychol Med. 2006;36:575-86.
Questions & Answers

Please type your question in the text chat box
PCSS-O Colleague Support Program

- PCSS-O Colleague Support Program is designed to offer general information to health professionals seeking guidance in their clinical practice in prescribing opioid medications.
- PCSS-O Mentors comprise a national network of trained providers with expertise in addiction medicine/psychiatry and pain management.
- Our mentoring approach allows every mentor/mentee relationship to be unique and catered to the specific needs of both parties.
- The mentoring program is available at no cost to providers.

For more information on requesting or becoming a mentor visit: pcss-o.org/ask-colleague

- Listserv: A resource that provides an “Expert of the Month” who will answer questions about educational content that has been presented through PCSS-O project. To join email: pcss-o@aaap.org.
PCSS-O is a collaborative effort led by American Academy of Addiction Psychiatry (AAAP) in partnership with: Addiction Technology Transfer Center (ATTC), American Academy of Neurology (AAN), American Academy of Pain Medicine (AAPM), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Dental Association (ADA), American Medical Association (AMA), American Osteopathic Academy of Addiction Medicine (AOAAM), American Psychiatric Association (APA), American Society for Pain Management Nursing (ASPMN), International Nurses Society on Addictions (IntNSA), and Southeast Consortium for Substance Abuse Training (SECSAT).

For more information visit: www.pcss-o.org
For questions email: pcss-o@aaap.org

Twitter: @PCSSProjects

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