

MEDICAL SCHOOL AND RESIDENCY PROGRAM  
CURRICULUM RESOURCES ON DRUG ABUSE AND ADDICTION

# Knowing When to Say When: Transitioning Patients from Opioid Therapy

University of Massachusetts Medical School  
(Massachusetts Consortium)

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<http://www.drugabuse.gov/coe>

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# CASE STUDY

## Introduction

Chronic pain is most often managed in outpatient primary care settings; however, many providers may feel they are poorly prepared and lack the resources to manage these conditions (Bhamb et al., 2006; Upshur, Luckmann, & Savageau, 2006). Opioid analgesics are among the most effective medications for decreasing pain (including non-cancer pain), but they are also associated with serious and increasing public health problems, including addiction and deaths. For example, rates of abuse of opioid medications and overdose deaths from prescription opioids have increased dramatically over the last two decades (Okie, 2010; Paulozzi, Budnitz, & Xi, 2006; Paulozzi, Weisler, & Patkar, 2011). Improving the safety and efficacy of opioid prescribing for pain has become a major priority for federal agencies, medical professional societies, state licensing boards, and state departments of public health (Office of National Drug Control Policy, 2011; Okie, 2010; Volkow & McLellan, 2011).

When prescribing opioids, providers must balance the rights of patients to access effective pain treatment with the physician's responsibility to ensure that medications are prescribed safely and used appropriately (Volkow & McLellan, 2011). In the last decade, a number of clinical guidelines for the use of opioids to treat chronic nonmalignant pain have been published that outline procedures recommended as part of the initiation and ongoing monitoring of outpatient opioid treatment (Chou et al., 2009; Department of Veterans Affairs, 2010; Federation of State Medical Boards, Inc., 2013; Gourlay, Heit, & Almahrezi, 2005; Washington State Agency Medical Directors' Group, 2010 Update). These recommendations include several steps to take before prescribing that include obtaining informed consent, implementing treatment agreements, screening for substance use and mental health disorders, and conducting urine toxicology screening. Steps for evaluating patients during treatment are also recommended, including monitoring for pain relief, functional improvement, medication side effects, and behaviors that could suggest misuse of the medications.

A critical component of treatment not covered extensively in these guidelines is when and how to taper and/or transition patients off of opioid-based medications. Medical providers must be able to recognize when safety is compromised and when drug misuse or diversion is occurring. Providers must also be familiar with local specialty treatment resources for both pain and addiction, and understand how to transition patients to these other sources of care safely and effectively. Without these skills, three potential situations arise. First, providers may continue prescribing opioids even when there are significant signs that the treatment is unsafe or ineffective. Second, patients may suffer opioid withdrawal or other health and social consequences if medications are stopped unnecessarily and/or abruptly before the patients are linked to other forms of care. Finally, without this knowledge, providers may be reluctant to provide opioid treatment for chronic pain due to a lack of confidence in their ability to monitor this treatment, therefore limiting patient access to this modality.

The goal of this module is to help providers recognize and manage problematic behaviors that may arise in patients taking opioids, and, when necessary, transition patients to more structured or alternative types of care. The module consists of a two-part case study, focusing on a hypothetical patient who is maintained on opioids for chronic back pain. Each section of the case study is followed by questions to help guide the discussion.

To learn more about the initial steps for managing patients with chronic nonmalignant pain, please visit National Institute on Drug Abuse's (NIDA's) Web site to view the [\*Minimizing the Misuse of Prescription Opioids in Patients With Chronic Nonmalignant Pain\*](#) curriculum resource.

## Learning Objectives

After completing this module, participants should be able to:

1. Describe aberrant drug-taking behaviors that may indicate opioid medication misuse and how to respond to these behaviors effectively in outpatient practice.
2. Describe strategies for monitoring patients who are prescribed opioids for signs of misuse of those medications.
3. Using a risk-benefit framework, describe conditions under which discontinuation of opioids may be considered.
4. Describe strategies for transitioning patients off of opioids and how to treat opioid withdrawal symptoms.
5. Discuss options for specialty addiction treatment for patients with chronic pain, including inpatient detoxification and opioid agonist modalities.
6. Discuss management of problematic behaviors that may arise when discontinuing opioids including declining to transition, drug addiction, disruptive or threatening behavior, and suicidality.
7. Discuss the principle of “abandonment” and list the steps that should be taken to minimize medico-legal risk when discontinuing opioid treatment.

## Background

The patient is a 45-year-old male with a history of hypertension, type II diabetes, and elevated cholesterol who presented with sudden onset of lower back pain after lifting heavy furniture about 1 year ago. The initial history and physical examination were consistent with acute L4-L5 disk herniation with nerve root compression. In the first few months following his injury, you managed him with nonsteroidal anti-inflammatory medications (NSAIDs), muscle relaxants, and some short-acting opioids, and encouraged him to remain active. When he didn't improve, a follow-up MRI showed that he had a herniated disk without significant nerve root compression. The patient was then referred for physical therapy and saw an anesthesia pain specialist who provided steroid injections. After 4 months, the patient still complained of significant pain and disability, so you decided to initiate a trial of long-acting opioids to help him get better pain control throughout the day and get back to work. Following the current guidelines, you had the patient review and sign both the informed consent and treatment agreement for opioids. You screened him for mental health and substance use disorders, and based on the results, worked with him to set up specific, measurable treatment goals and a monitoring plan that included regular urine toxicology screening. He had surgery due to continued pain and evidence on physical examination of nerve root compression at L5, but his pain symptoms and disability persisted after the operation. For the past few months, you have titrated his opioids and adjuvant nonopioid medications and followed him carefully to see that his pain and functioning were improving without any adverse effects from the medications.

# Part 1: Urgent Office Visit with Provider

## Current medications

Medication name	Dosage	Frequency
Ibuprofen	800 mg	1 tablet up to twice per day
Methocarbamol	750 mg	1–2 tablets once per day
Oxycodone/acetaminophen	5/325 mg	1–2 tablets up to twice per day
Oxycodone extended release	40 mg	1 tablet twice per day
Amitriptyline	100 mg	1 tablet at night
Lactulose 15 mg/5 ml	10 ml	Twice daily as needed
Dietary fiber supplements		1–2 per day

This is an acute care visit, added into your schedule because the patient called in saying he had run out of his medications early and needed more. In the office, he reports falling on ice outside his home leading to severe pain in his lower back. To manage, he had taken more of his prescribed opioids, using up the entire 4-week supply in only 2 weeks. He also took extra oxycodone tablets he had saved from a past dental surgery. He describes the pain as severe, “at least a 9 out of 10” on the numerical pain scale. On examination, he is afebrile and showing significant tenderness in the right lumbar paraspinal muscles where there is palpable muscle spasm, and diffuse tenderness in the entire lumbo-sacral region. There are no signs of nerve root compression. He is clearly uncomfortable, shifting position frequently and complaining it is difficult for him to sit down. He is also showing signs of moderate opioid withdrawal, with pupillary dilation, mild sweating and rhinorrhea, and complaints of stomach cramping. He is frustrated to be out of work again and upset that he had to come in for this visit today when he is so uncomfortable, asking why his wife couldn’t have picked up new prescriptions so that he could have stayed in bed.

A urine drug screen was done at the last visit and showed the following results:

Drug type	Screening result
Opiates	Negative
Barbiturates	Negative
Cocaine	Positive
THC	Positive
Benzodiazepines	Negative
Amphetamine	Negative

## Discussion questions

1. What are aberrant medication taking behaviors? Are some more or less concerning for misuse of opioid medication than others?
2. What is the differential diagnosis of this patient's irregular behaviors with his medications?
3. Is this patient addicted to opioids? Discuss the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) diagnostic criteria for substance use disorder and challenges in making that diagnosis in patients taking chronic opioids. What screening tools are available to help determine whether a patient is misusing his/her pain medications? Discuss the use of the [Current Opioid Misuse Measure](#) (COMM) questionnaire.
4. Describe the risk-benefit framework for managing chronic pain with opioids. How would you communicate these principles to this patient? What other symptoms or behaviors could indicate either too little benefit or too much risk to continue opioid prescribing? Are screening tools available to help assess patient functioning and whether a patient's pain medication is effective? Discuss the use of the [Pain Assessment and Documentation Tool](#) (PADT).
5. Why was this patient's opiate screen negative?
6. How will you discuss the positive results for cocaine and marijuana metabolites with this patient?
7. What are the next steps you would take in managing this patient's opioid medications? What changes from the previous treatment plan would you suggest to help monitor him? What resources or consultants would you consider accessing at this point in his care?



## Part 2: Office Visit with Provider 8 Weeks Later

### Current medications

Medication name	Dosage	Frequency
Ibuprofen	800 mg	1 tablet up to twice per day
Methocarbamol	750 mg	1–2 tablets once per day
Oxycodone/acetaminophen	5/325 mg	1–2 tablets up to three times per day
Oxycodone extended release	60 mg	1 tablet twice per day
Amitriptyline	100 mg	1 tablet at night
Lactulose 15 mg/5 ml	10 ml	Twice daily as needed
Dietary fiber supplements		1–2 per day

### Review of the patient's care over the last 8 weeks

During the urgent visit 8 weeks ago, you reviewed the treatment agreement again with this patient and decided to continue his opioid prescriptions with a temporary increase in the short-acting oxycodone for breakthrough pain (see Supporting Documents for a sample treatment agreement). You also increased the frequency of office visits and drug screening to increase the level of safety monitoring. Four weeks later, the patient showed no signs of improvement, so you increased his oxycodone extended release from 40 to 60 mg twice daily. No drug screen was done at this time. Around that same time, the patient saw an anesthesia pain specialist who did not recommend any further evaluation or treatment. In the last month, your nurse called the patient twice to come in for a random pill count and drug screen. The nurse left messages on his voicemail, but he never came in.

At today's visit, the patient reports the pain related to the fall has improved, but his overall pain level remains high, at least a 9 out of 10 most days with pain level reduced only to 6 or 7 with the medications. He has still not been able to work and is asking to increase the extended-release oxycodone to 80 mg twice daily. He also reports significant depression and very poor sleep. He denies alcohol and any further cocaine use, but says he has been using marijuana regularly to help with pain and sleep. He occasionally takes an extra 5 mg oxycodone when his depression symptoms are bad because it "gives me energy and I can function better." You notice that he looks a little sleepy and that his speech is occasionally slurred. You also check your state's online prescription drug monitoring program (<http://www.pmpalliance.org/>) and find that the patient has been receiving prescriptions for short-acting oxycodone, hydrocodone, and diazepam from a number of providers outside your office for the last 3 months. He says this is because he can't sleep and you aren't giving him enough medication to treat his pain effectively.

### Discussion questions

1. How will you communicate to this patient that you feel it is necessary to transition him from outpatient pain management in your office to another provider?
2. How would you safely taper him off of the opioid medications?
3. What if he does not agree with the plan or cannot limit the amount of medications that he uses? Describe circumstances under which opioids should immediately be stopped.
4. Does this patient meet diagnostic criteria for addiction now? What addiction treatment options are there for him, and what challenges might he face in accessing those treatments?
5. Discuss the following hypothetical patient statements:
  - a. "If you won't prescribe these, I will just have to buy them on the street."
  - b. "You can't do this. I'm calling a lawyer". What are your legal obligations?
  - c. "If you stop my medications, I will kill myself."

# FACULTY GUIDE

The questions in this faculty guide are intended to be posed to a group of learners by a facilitator. The questions are designed to stimulate discussion on how best to care for patients and ensure appropriate administration of opioid medications. Although the questions do not specifically address coordination of care, facilitators are encouraged to discuss how care can be coordinated to maximize benefits for patients.

## Case Study Part 1: Discussion Questions

### 1. What are aberrant medication-taking behaviors? Are some more or less concerning for misuse of opioid medication than others?

References: (Passik, 2009; Portenoy, 1996)

Aberrant medication-taking behaviors are irregular behaviors that could suggest a substance use disorder as defined by DSM-5. Please see the State Federation of Medical Boards 2013 publication [\*Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain\*](#) (section iii, definitions) for a glossary of terms related to chronic opioid therapy and addiction frequently used in this curriculum resource.

Some aberrant medication-taking behaviors are very concerning even when they happen once. This is referred to as a “red flag” behavior. Other behaviors seem less serious but may become more concerning when they occur repeatedly over time. These behaviors are referred to as “yellow flags.”

“Red flag” behaviors include serious behaviors that could suggest of misuse or addiction such as:

- Deterioration in functioning at work or socially
- Illegal activities—selling medications, forging prescriptions, or buying medications from nonmedical sources
- Using medications in ways other than prescribed (e.g., injecting or snorting medication)
- Multiple reports of lost or stolen prescriptions
- Resistance to change in medications despite adverse effects
- Refusal to comply with random drug screens, call backs, or pill counts
- Concurrent abuse of alcohol or drugs
- Use of multiple physicians and pharmacies

“Yellow flag” behaviors can include those that on their own could represent normal behaviors associated with acute or chronic pain, but combined may be of concern for a substance use disorder include:

- Complaints about need for more medication
- Drug hoarding (e.g., saving up/using medications from past prescriptions)
- Nonadherence to recommendations for non-medication pain therapies
- Acquiring similar medications from other providers
- Occasional unsanctioned dose escalation
  - Although these last two behaviors can be a normal part of pain management, they also can represent significant safety risks. If a patient is seeking and taking more opioids than what the prescriber recommends, he or she could be at significant risk for opioid overdose and overdose death.

- Requesting specific pain medications
  - o Medical providers are often trained to recognize this as a sign of medication misuse. Taken in the context of a patient’s presentation and history, this could be a sign of “seeking” certain medications.
  - o On the other hand, if patients ask for specific medications, it should not be immediately assumed that he or she is “drug seeking.” Patients who have been in treatment for a while will often have experience with multiple medications. Also, if a patient reported a specific blood pressure medicine worked well in the past, providers would likely restart it immediately, rather than avoiding it.

Providers have to ask themselves how many times can a patient exhibit these more moderate behaviors before they become “red flags”—signs that something more serious or dangerous is going on.

## **2. What is the differential diagnosis of this patient’s irregular behaviors with his medications?**

References: (Passik, Portenoy, & Ricketts, 1998; Savage, 2002)

The provider needs to determine whether the patient is legitimately seeking medications for the treatment of his pain or if his behavior suggests that he is using medications for recreational purposes.

“Drug seeking” is defined as patients seeking medications for reasons other than the treatment of pain. These drug-seeking behaviors may indicate substance use disorder or addiction.

- Substance use disorder
  - o Substance use disorder is measured on a continuum from mild to severe, based on the level of impairment. See pages 9 and 10 for the DSM-5 definition for substance use disorder.
- Addiction
  - o Addiction is a chronic, relapsing disease characterized by loss of control over drug use, compulsive use and/or craving, and ongoing use despite negative consequences and is defined by the [American Society of Addiction Medicine](#) as, “A primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.”
- Criminal activity
- Selling or sharing of medications
- Psychiatric conditions
- Self-medication of mood states, depression, anxiety, mania
- Cognitive impairment due to medical and mental health conditions including, but not limited to, mania, psychosis, traumatic brain injury, dementia, hepatic encephalopathy, intoxication with drugs or alcohol.

“Treatment seeking” occurs when patients are legitimately seeking additional medications primarily for the treatment of a condition such as:

- Worsening pain, from either undertreatment or progression of an existing condition, or pain from a new condition or “pain generator” possibly related to the reported injury.
- Progressive physiological dependence on opioids, leading to:
  - o Tolerance, defined as experiencing a decreased effect from the same dose of medication, or needing increased amounts of medication to achieve the same effect
  - o Withdrawal or abstinence syndrome symptoms
- Hyperalgesia
  - o Increased sensitivity to painful stimuli documented in patients on chronic opioids, particularly those in methadone maintenance
- Pseudo-addiction
  - o Behaviors that look like substance use disorder or addiction, but resolve when pain treatment is optimized

**3. Is this patient addicted to opioids? Discuss the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* diagnostic criteria for substance use disorder and challenges in making that diagnosis in patients taking chronic opioids. What screening tools are available to help determine whether a patient is misusing his/her pain medications? Discuss the use of the [Current Opioid Misuse Measure \(COMM\)](#) questionnaire.**

References: (Manchikanti, Atluri, Trescot, & Giordano, 2008; Savage, 2002; Savage, Kirsh, & Passik, 2008)

To determine whether the patient has a substance use disorder (e.g., is addicted to opioids), there are two key considerations:

**1. Physical dependence does not necessarily indicate the patient has a substance use disorder.**

Physical dependence, tolerance, and withdrawal are expected results of taking opioid medications but do not, on their own, indicate that a patient has developed addiction unless other behaviors are present.

Physical dependence occurs when a body adapts to the presence of a substance and shows a specific pattern of withdrawal symptoms when the substance is stopped or rapidly decreased. Physical dependence and tolerance are expected in the setting of prolonged opioid therapy and are not the same as addiction.

Physical dependence and withdrawal on cessation of a substance happen with regular administration of many classes of medication—such as opioids, benzodiazepines and barbiturates—even when they are taken as prescribed. The development of physical dependence should be expected as part of chronic opioid therapy.

Addiction is a chronic neurobiological disease. Genetics, psychosocial factors, and environmental influences all contribute to its development. Characteristic addictive behaviors include loss of control over drug use, craving, compulsion to use, and continued use despite negative consequences.

**2. The diagnostic criteria for substance use disorder are difficult to apply to patients with chronic pain who take opioids.**

Many of the behaviors described in the DSM-5 criteria may arise as part of a chronic pain syndrome and its treatment. Patients with chronic pain as a result of a chronic condition who are prescribed opioids may exhibit behaviors that suggest addiction, but may be normal behaviors for many patients with such a

chronic condition. For a physician to diagnose a substance use disorder according to the DSM-5, two or more of the following criteria must be met:

1. Taking the substance in larger amounts or for longer periods than was originally intended
2. Wanting to cut down or stop using the substance but reporting multiple unsuccessful efforts to do so
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Experiencing cravings and urges to use the substance that most often occur in an environment where the drug was previously obtained or used
5. Failing to perform major role obligations at work, home, or school because of substance use
6. Continuing to use, even when it causes persistent problems in social or interpersonal relationships
7. Giving up important social, occupational, or recreational activities because of substance use
8. Using the substance in situations in which it is physically hazardous
9. Continuing to use, even when aware of a physical or psychological problem that could have been caused or exacerbated by the use of the substance
10. Needing more of the substance to get the desired effect (tolerance)
11. Using the substance to relieve the symptoms of withdrawal

The DSM-5 defines the severity of the substance use disorder as:

1. Mild, if 2–3 criteria are met
2. Moderate, if 4–5 criteria are met
3. Severe, if 6 or more criteria are met

Criteria 1 and 2 potentially would not be useful to identify patients with substance use disorder because anyone taking opioids for a long period of time will develop tolerance and will experience withdrawal if the medications are abruptly discontinued. The DSM-5 specifies that for patients taking medications as prescribed, developing tolerance and exhibiting symptoms of withdrawal are not diagnostic criteria for a substance use disorder.

Patients who take prescribed opioids may exhibit the behaviors described in criteria 3, 4, 5, and 6 due to the presence of tolerance and withdrawal symptoms, and also if their pain control is not optimal. In some cases, some of the behaviors described in criteria 7 to 11 might be seen in patients who have been prescribed opioids. However, if patients are taking the medications as prescribed and experiencing these negative effects, it would indicate dangerous prescribing or a prescribing error, not a substance use disorder. The key would be to see if the behaviors decreased or disappeared after medication dosing was optimized.

The [Current Opioid Misuse Measure \(COMM\)](#) is a questionnaire that helps providers identify patients on opioid therapy who may be exhibiting behaviors that could suggest the misuse of prescribed opioids.

**4. Describe the risk-benefit framework for managing chronic pain with opioids. How would you communicate these principles to this patient? What other symptoms or behaviors could indicate either too little benefit or too much risk to continue opioid prescribing? Are screening tools available to help assess patient functioning and whether a patient’s pain medication is effective? Discuss the use of the Pain Assessment and Documentation Tool (PADT).**

Reference: (Chou et al., 2009)

The risk-benefit framework for managing chronic pain with opioids spans the continuum of too little benefit to too much risk.

### **Too little benefit**

Examples of not experiencing sufficient benefit from opioid treatment include:

- Inadequate analgesia
- No improvements in function
- Not meeting treatment goals

### **Too much risk**

Examples of increased risk related to opioid treatment include:

- Adverse events
  - Side effects such as sedation or impairment of mental functioning
  - Respiratory depression or opioid overdose
  - Development of serious medical conditions related to opioids, such as sleep apnea
- Increasing dose without increasing benefit
  - Dose increases should lead to improvements in pain and function. If not, then dose increases add to the risk without increasing the benefit.
  - Tolerance happens. However, while patients habituate to the analgesic effects of the opioids, they may not habituate to the respiratory depression and other central nervous system side effects. They may, therefore, be at increased risk for overdose.
- Requesting increases in doses without other evidence indicating that the patient's pain condition is worsening or that he or she has developed a new condition causing pain.
  - These requests could represent compulsive use, craving, and/or use for reasons other than pain, such as use for relief of depression or other mental health symptoms.
  - Hyperalgesia may occur (i.e., patients perceive and experience other painful stimuli more severely because they have been taking opioids for long periods of time). Increases in opioid doses in this situation will show little benefit and may worsen patients' symptoms.
- Addiction
  - Loss of control over use
  - Craving, compulsive use
  - Use despite negative consequences

Examples of increased risk associated with psychosocial issues may include:

- Psychiatric instability: depression, mania, suicidal ideation or attempts
- Unstable housing
- Inability to store medications safely or securely
- Noncompliance with monitoring procedures
- Noncompliance with office procedures described in the signed treatment agreement
- Misuse of alcohol or other drugs
- Diversion or criminal behavior

Additional considerations for determining if there is too little benefit or too much risk to continue opioid prescribing:

- If the patient is not showing improvement on the analgesia and activity sections of the PADT, the provider needs to determine whether the patient is getting sufficient benefit from the treatment.
- Some types of pain may be less responsive to opioids than others.
  - Acute pain may be more responsive than chronic pain.
  - Nociceptive pain may be more responsive than neuropathic pain.
- Opioid sensitivity varies because of genetic differences among individuals.

- Remember, more opioid treatment is not necessarily better or safer treatment.
  - Chronic opioid treatment may lead to increased sensitivity to painful stimuli. This phenomenon is sometimes called hyperalgesia, a condition in which increasing opioid dosing may actually make the experience of pain worse.
  - Some guidelines are beginning to emphasize that there should be a maximum opioid dose beyond which the risk may no longer be justified by the benefits and that doses higher than certain thresholds should only be managed by pain specialists (Washington State Agency Medical Directors Group, 2010). No concrete or specific cut-off dose is currently defined at the national level.
  - Increased risk of opioid overdose has been associated with increased daily prescribed opioid doses (Dunn, 2010; Gomes, 2011).

## 5. Why was this patient's opiate screen negative?

References: (Christo et al., 2011; Gourlay, Heit, & Caplan, 2010; Manchikanti et al., 2008)

There are two commonly used techniques for urine drug testing:

- Immunoassays, in which engineered antibodies bind to drug metabolites
- Gas/liquid chromatography-mass spectrometry (G/LCMS), which is able to directly measure specific drug metabolites

### Immunoassays

- They are quick, easy, and relatively inexpensive.
- Most initial drug testing is done with immunoassays, even in hospital labs.
- Immunoassays are available as dipstick or cup tests that can be "CLIA waived" and used in office practice; these often include a standard panel:
  - Opiates, cocaine, marijuana, benzodiazepines (+/- barbiturates, amphetamines).
- Results are based on finding a certain level of drug metabolite in the urine:
  - Cutoffs vary among labs and regulating agencies and can be quite high, meaning that low levels of metabolite in a patient's urine might be missed and cause a "false negative" test result.
- Cross-reactivity can occur with other drugs and medications, potentially causing "false positive" test results.

### G/LCMS

- This technique provides direct measurement of drugs or drug metabolites and can give quantitative results.
- False positives are minimized, but they may still occur:
  - For example, fluoroquinolones may give a false positive for opiates.
- They are expensive and technically complicated, available only in specialized labs.
- These are typically used to:
  - Confirm positive screening results.
  - Resolve questions of false positive screens.
  - Test for substances for which immunoassays are unreliable or unavailable.

### Possible reasons for negative opiate screens

- The opiate screen may be negative due to limitations of the opiate immunoassay in detecting semisynthetic and synthetic opioids. Oxycodone does not reliably show a positive on the opiate immunoassay because it is a semisynthetic opioid. Immunoassays for opiates are based on finding morphine in the urine, which is the metabolite for morphine, codeine, and heroin.

- These tests do not reliably detect synthetic and semisynthetic opioids, such as oxycodone, hydrocodone, methadone, buprenorphine, or fentanyl.
- If a provider needs to test for the presence of synthetic and semisynthetic opioids, he or she must order specific testing for these agents and communicate with the lab to make sure that the right type of testing is used for each patient.
- Some companies are making immunoassay tools that specifically target some of these drugs, but they are separate tests from the opiate screen.

The absence of a positive opiate screen may be reassuring because it suggests there are no morphine or morphine derivatives (such as heroin) in the patient's system. However, oxycodone and/or hydrocodone metabolites at higher levels may cross-react with some opiate immunoassays, so a positive screen would not automatically indicate opioid abuse and should be confirmed with G/LCMS before any action is taken.

## **6. How will you discuss the positive results for cocaine and marijuana metabolites with this patient?**

The use of marijuana is a violation of the patient's treatment agreement, but some may argue it is not grounds for changing the treatment and monitoring plan, especially as some states have adopted laws legalizing medical marijuana.

Cocaine use is often seen by medical providers and society as more serious drug use. Any drug or alcohol abuse is a risk factor for misuse of opioid medications and should trigger more intensive monitoring and possibly referrals to addiction treatment or specialty pain treatment.

Providers should consider using a brief intervention and/or a chronic disease approach to help address drug use with patients.

- Consider a brief intervention:
  - o Providers might consider discussing positive test results via a brief intervention (BI) with the patient. A BI is a patient-counseling technique that is usually grounded in motivational interviewing—a nonconfrontational approach that starts with assessing the patient's understanding of his or her substance use and readiness to change. From there, the clinician provides feedback and information about the patient's own ambivalence or concerns about his or her substance use. The clinician aims to help patients move through the stages of change at their own pace and to help them to identify and reduce the harms of their substance use. It is important to meet the patient where he or she is, and to use a nonjudgmental tone.
- Consider a chronic disease approach:
  - o This discussion could begin with a question posed by the facilitator to the group: If patients with diabetes or hypertension were doing poorly or showing signs of behaviors that could worsen their conditions, what are the ranges of possible responses?
  - o Most providers would intensify treatment by increasing the frequency of visits and monitoring and by adding additional treatment modalities. The same principles apply here. This patient could be seen weekly, with weekly refills and drug screens for a while until the results are more reassuring. The provider could mandate concurrent mental health and/or substance abuse treatment.
  - o Ideally, providers should be able to refer patients needing pain treatment who have co-occurring substance-related disorders to providers who specialize in that type of treatment, just as is done for patients with diabetes or hypertension that is difficult to



manage. The problem is that those specialized pain treatment resources may be scarce or nonexistent in many areas.

Ultimately, each provider will need to make a decision about whether or not the risks of continuing treatment while a patient is using illegal drugs outweigh the benefits to the patient in terms of pain control, improved function, and productivity.

## **7. What are the next steps you would take in managing this patient's opioid medications? What changes from the previous treatment plan would you suggest to help monitor him? What resources or consultants would you consider accessing at this point in his care?**

References: ("Effective Medical Treatment," 1998; Dobscha et al., 2009; Manchikanti et al., 2008; Savage, 2002; Savage et al., 2008; Wiedemer, Harden, Arndt, & Gallagher, 2007)

Should additional opioid medications be prescribed to treat the acute pain of the reported injury? Consider offering the group the provider "archetypes" listed below to stimulate the discussion.

- "Dr. Easy" might provide early refills right away, considering that with time pressures in office practice this would be the quickest way to satisfy the patient and move on to the next patient. "Dr. Easy" would give a month's supply of additional short-acting opioids to cover the acute pain from the injury right away.
- "Dr. Hard Core" might refuse to provide early refills, arguing that the patient has violated the treatment agreement and should wait until his regularly scheduled appointment. "Dr. Hard Core" might discontinue meds altogether, arguing that the patient is not managing the medications safely, may meet criteria for addiction, and should be in more structured specialty care.
- "Dr. Middle Ground" might provide early refills once and perhaps offer additional medications to manage pain from the reported acute injury but would also allow some time to evaluate the full differential diagnosis of the observed aberrant behaviors. "Dr. Middle Ground" would take this as an opportunity to reevaluate, enhance, and intensify the treatment with the following steps:
  - o Review the treatment agreement and make sure all parties are clear on expectations and parameters for safe management of opioids
  - o Optimize non-opioid medications
  - o Decrease the prescription intervals to every 1 to 2 weeks
  - o Increase the frequency of visits
  - o Order a drug screen (e.g., urine) to detect the presence of synthetic and semi-synthetic opioids
  - o Use a screening tool (e.g., [NIDA Drug Use Screening Tool](#), Drug Abuse Screen Test [[DAST-10](#)]) to obtain a more thorough assessment of current substance use
  - o Deliver a BI
  - o Plan for a random call back with pill count
  - o Check the state's prescription drug monitoring program (<http://www.pmpalliance.org/>)
  - o Require additional therapeutic modalities or consultations, such as physical therapy, massage, pain specialty provider
  - o Involve a family member in safety monitoring (e.g., obtaining patient consent for communication of relevant treatment information, asking family members to provide appointment reminders and to ensure that the patient can make appointments, making the home environment free of substances that may be misused, engaging in lifestyle changes to support the patient's care plan)

Additional resources and consultants to consider include:

**Pain treatment specialist**

Is there a medically based pain specialty treatment program in the area that provides comprehensive care to higher risk patients? Is there a psychiatrist or physical medicine specialist who cares for patients with pain in the provider's area? Has there been an evaluation by an anesthesia pain specialist?

**Addiction treatment providers**

Is there an opportunity to refer this patient for addiction assessment or comanage with an addiction treatment team?

**Mental health provider**

Is there a need/opportunity for diagnostic evaluation and ongoing mental health treatment? What resources are there for this type of care, as well as psychiatry and/or other providers of psychopharmacology?

**Physical therapy**

A skilled physical therapist can perform a careful assessment of musculoskeletal pain that may help clarify the etiology of the pain and offer a number of nonpharmacological treatment options.

**Alternative or Complementary therapies**

Using safe and complementary therapies such as chiropractic care, acupuncture, and Alcoholics Anonymous/Narcotics Anonymous or other 12-Step community-based recovery support resources may be explored to enhance treatment.

## Case Study Part 2: Discussion Questions

### 1. How will you communicate to this patient that you feel it is necessary to transition him from outpatient pain management in your office to another provider?

Reference: (Washington State Agency Medical Directors' Group, 2010 Update)

This patient will be transitioned from outpatient opioid treatment in your office to another provider. The treatment plan is being changed, but this does not mean that the patient will be discharged from your office practice. There are several approaches to consider for how best to communicate this change to the patient.

- Anticipate the patient's distress and provide reassurances that you are not abandoning him.
- Describe the decision in terms of risk/benefit. Be clear—this is about safety, not a judgment of the patient
- Describe/list the specific behaviors that have led to the determination that the risk is too great to continue.
- Explain that the lack of improvement suggests that the current treatment approach is not effectively managing the patient's pain treatment goals.
- Reinforce your commitment to work with patient:
  - Consider saying, "I am committed to helping you in any way I can that is safe, but I have determined, due to (list behaviors here), that it is no longer safe to continue to prescribe you these medications because they do not appear to be effectively improving your function."
  - Avoid saying, "I am not comfortable prescribing these medications for you anymore." This statement is confusing to patients because they are the ones who are in pain or uncomfortable, not the provider. The provider's language should reflect the risk-benefit analysis being considered to assess the patient and the treatment.
  - Explain that the patient's function may improve on lower doses
  - Describe steps to minimize withdrawal symptoms
  - Describe safer pain management options you will pursue
- Maximize nonopioid modalities
- Refer to specialty pain treatment
- Describe what options there are if patient does not tolerate or is unsafe during withdrawal
- See patient frequently to evaluate progress and monitor for safety

### 2. How would you safely taper him off of the opioid medications?

References: (Kosten & O'Connor, 2003; Washington State Agency Medical Directors' Group, 2010 Update)

Not all patients need to be withdrawn from an opioid, and it is important for this to be recognized by the clinician. Exposure to steady-state level of medication is what leads to neuroadaptation to opioids and the emergence of withdrawal after medications are decreased or discontinued. Patients who are taking short-acting opioids infrequently or once daily should not develop withdrawal symptoms. Patients who are taking higher doses, who are frequently dosed, or who are taking long-acting opioids are at risk for withdrawal.

#### Tapering

When patients are on both long- and short-acting opioids, it may be easiest to taper the long-acting opioids first, allowing continued use of short-acting medications for breakthrough pain.

### *Tapering long-acting opioids*

- Decrease by 10 to 20 percent each week
- Pill formulations may dictate amount of drop in dose. For example, if long-acting oxycodone comes only in 10 or 20 mg tablet increments, it would be hard to decrease by doses less than 10 or 20 mg at a time.
- The rate of the taper would be determined by the treatment circumstances. If the provider can safely decrease more slowly, then the slower the better to minimize withdrawal symptoms.
- Consider prescribing a supply of short-acting, opioid-based medications to treat breakthrough symptoms
  - This may decrease withdrawal symptoms, and allow more time to build up alternative pain treatment modalities.
- Consider safe medications that may help treat withdrawal symptoms.

### *Tapering short-acting opioids*

- Decide if you need a taper at all?
  - Is there physiological dependence?
  - Has the patient actually experienced a prolonged steady-state level of the medication, sufficient enough to lead to neuroadaptation at the receptor level?
- Decrease the strength of the tablets and/or decrease by a specific number of tablets each week.
- Substitution with long-acting medications to facilitate taper is not recommended outside of a methadone or buprenorphine treatment program.

## **Recognizing symptoms of opioid withdrawal**

- Increased heart rate
- Sweating/hot flashes
- Chills
- Restlessness, poor sleep
- Dilation of pupils
- Bone/joint aches
- Runny nose/tearing of eyes
- Stomach cramping, progressing to nausea, loose stools, vomiting, and diarrhea
- Tremors
- Yawning
- Anxiety/irritability
- Piloerection, called “gooseflesh” or “cold turkey”

Consider using the [Clinical Opiate Withdrawal Scale \(COWS\)](#) to rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time; see Supporting Documents.

## **Considerations for treating withdrawal symptoms**

Consider some of the following options for treating opioid withdrawal symptoms with nonopioid medications when they can be used safely.

### *Clonidine: oral dosing*

- Initial dosing: 0.1 mg po. Watch blood pressure carefully
- Titrate from 0.1 up to 0.3 mg po q 4-6 hours if tolerated, then taper
- Risk: Hypotension
- Effective adjuvant to other meds listed

#### *Clonidine: transdermal (patch)*

- More steady levels of medication; prevents cyclic hypotension and rebound
- Dosed one patch per week (\$10/patch)
- Dose range: 0.1 to 0.4 mg
- 24–48 hours to start to work—can use oral clonidine initially while waiting for effect.

#### *Analgesics*

- NSAIDs: Ibuprofen, Naproxen
- Acetaminophen
- Avoid Tramadol because it is an opioid-like medication.

#### *Antispasmodics (for abdominal cramping)*

- Dicyclomine (Bentyl), 20 mg 4 times daily

#### *Decongestants*

- Pseudoephedrine, 30 to 60 mg 4 times daily
- Phenylephrine, 10 mg 4 times daily

#### *Antiemetics*

- Prochlorperazine (Compazine), 5 to 10 mg 3 times daily
- Promethazine (Phenergan), 25 mg 4 times daily
- Metochlopramide (Reglan), 10 mg 4 times daily

#### *Muscle relaxants*

- Cyclobenzaprine (Flexeril), 5 to 10 mg 3 times daily
- Methocarbamol (Robaxin), 1000 to 1500 mg up to QID
- Do not prescribe SOMA (Carisoprodol): metabolized to a barbiturate and therefore causes physical dependence and risk of withdrawal symptoms when discontinued

#### *Antidiarrheals*

- Kaolin with Pectin
- Bismuth HCL (Pepto-Bismol)
- Loperamide (Imodium)

#### *Sleep aids*

- Diphenhydramine (Benadryl), 50 mg
- Trazodone (Desyrel), 50 to 100 mg
- Amitriptyline (Elavil), 50 mg

Avoid benzodiazepines, which also cause physical dependence and carry risks of developing withdrawal symptoms, substance use disorder, and overdose.

### **3. What if the patient does not agree with the plan, or cannot limit the amount of opioid medications being used for the taper? Describe circumstances under which opioids should immediately be stopped.**

References: Fishbain, Lewis, Gao, Cole, & Rosomoff, 2009a; Fishbain, Lewis, Gao, Cole, & Rosomoff, 2009b

If the provider has determined it would not be safe to continue opioids long term, considering setting a reasonable tapering schedule and sticking to it. If the patient is unable to adhere to the tapering schedule

or uses more medications than he or she is allotted, that is a sign of loss of control and may qualify the patient for addiction treatment. If the patient becomes unsafe with the taper, providers may have to refer him or her to addiction treatment more urgently.

Emergency discontinuation of medications is considered only when it becomes acutely unsafe to continue to provide a supply of opioids to a patient. In these cases, patients would need to be referred immediately to more intensively monitored treatment settings. Examples of some of these situations might include:

- Dangerous alcohol or drug use
- Dangerous use of other prescribed medicines
- Opioid overdose, either alone or in combination with other medications
- Observed (or reliable reports of) sedation or impairment due to medications (this is even more concerning if sedation or impairment is observed on multiple occasions)
- Suicidal ideation/intent or suicide attempt
- Threatening behavior to staff or patients
- Criminal activity, such as diversion of medication or forging prescriptions

**4. Does this patient meet diagnostic criteria for addiction now? What addiction treatment options are available to them, and what challenges might they face in accessing these treatments?**

References: ("Effective Medical Treatment," 1998; Gunderson & Fiellin, 2008; Kleber, 2008; Manchikanti et al., 2008; Savage, 2002; Savage et al., 2008)

Once it is determined that this patient meets the diagnostic criteria for addiction, addiction treatment options should be explored. Challenges may arise for the patient to access treatment and working with the patient can facilitate the process.

**Table 1: Recognizing Opioid Misuse and/or Addiction in Patients on Chronic Opioid Therapy**  
(Adapted from: Savage et al., 2008; Manchikanti et al., 2008)

<b>Components of Addiction</b> <i>The "3 Cs"</i>	<b>Possible Expressions in Patients on Chronic Opioid Therapy</b>
Loss of <u>C</u> ontrol	<ol style="list-style-type: none"> <li>1. Reports lost/stolen medications</li> <li>2. Uses medication supply in short periods of time and calls for early refills</li> <li>3. Seeks opioids from other sources</li> <li>4. Exhibits withdrawal symptoms at appointments</li> </ol>
<u>C</u> raving, preoccupation with use, compulsive use	<ol style="list-style-type: none"> <li>1. Recurring requests for increases in opioids</li> <li>2. Increasing pain despite lack of progression of disease</li> <li>3. Dismisses nonopioid treatments</li> <li>4. Focuses on medications and not on other activities</li> </ol>
Use despite negative <u>C</u> onsequences	<ol style="list-style-type: none"> <li>1. Significant side effects, such as sedation and cognitive impairment</li> <li>2. Overdose</li> <li>3. Decreases in activity, functioning, and/or relationships</li> </ol>

**Addiction treatment options**

*Inpatient detoxification units*

- Admissions are usually patient initiated and voluntary.
- The typical length of stay is often quite short, such as 4 to 5 days.
- Insurance coverage varies.

- A diagnosis of opioid addiction not just physiological dependence is usually required, because the treatment is addiction focused, rather than pain focused.
- These units may be community based and managed by nursing staff, with limited access to physicians, labs, pharmacy, and other ancillary services. Patients and providers should not expect that patients will receive a pain physician consultation or hospital-level treatment on these units.
- This inpatient treatment is usually reserved for the most unstable or unsafe patients. If patients are tolerating a gradual outpatient taper, they should not be referred for inpatient detoxification. Shorter, faster inpatient treatment will be less likely to succeed than a gradual taper.
- Be aware that it may be difficult to place patients with serious mental health or medical comorbidities in a detoxification unit. Advocacy on the part of the provider may be needed to access treatment.

#### *Outpatient methadone programs (i.e., Opioid Treatment Programs (OTP))*

- These programs provide highly structured opioid agonist treatment, or maintenance therapy.
- Patients present for daily observed dosing of long-acting opioid (methadone) to stabilize withdrawal symptoms and help eliminate drug use.
- There is regular monitoring for drug and alcohol use.
- With infrequent exceptions, doses can be titrated to match the severity of each patient's withdrawal symptoms.
- These programs can provide a controlled, gradual taper over time.
- In most programs, behavioral treatment to help manage addiction behaviors is mandatory.
- Why consider methadone programs?
  - Because they work ("Effective Medical Treatment," 1998)
  - More than 50 years of research and treatment experience has shown these programs to be very effective.
  - Eighty to 90 percent of patients with substance use disorder relapse to drug use when out of treatment.
  - These programs increase treatment retention, and lead to an estimated 80 percent decrease in drug use and crime and 70 percent decrease all cause death rates.
- What are the limitations or drawbacks to methadone programs, especially for patients with pain?
  - Once daily dosing of methadone is rarely effective for pain control.
  - These programs are focused on addiction recovery, not on pain relief.
  - Long-term concurrent opioid prescriptions are not often allowed.
  - Patients can take weeks to months to reach a stable dose of methadone.
  - Daily attendance is required, which creates significant time, work, and transportation barriers for patients.
  - Methadone treatment is not covered by some Medicaid programs and many private insurers.
  - Patients complain that being in treatment with other patients with substance use disorder may expose them to patients at earlier stages of recovery and put them at risk for continuing drug abuse.
  - There is significant stigma associated with these programs. Patients experience this stigma from friends, family, employers, and medical providers.
  - Methadone itself is an opioid drug, and physical dependence will develop, requiring patients to taper off gradually to avoid withdrawal symptoms.

#### *Office-based buprenorphine treatment (OBOT)*

- Buprenorphine is a partial opioid agonist that has a lower overdose risk and may result in lower intensity withdrawal symptoms when patients taper.

- It comes in tablets and films mixed with naloxone, an opioid antagonist, in order to reduce the risk of misuse by injection.
- It is available for outpatient office-based treatment, in addition to treatment in specialty addiction treatment centers.
- It is more convenient for patients because they can take the medication at home and control the dosing times.
- It may be used for maintenance or detoxification treatment.
- Limitations/drawbacks to buprenorphine include:
  - o Buprenorphine has weaker agonist activity at the mu opioid receptor and therefore may not be strong enough to stabilize withdrawal in patients with higher levels of opioid tolerance.
  - o In many cases, buprenorphine will effectively block out other opioid pain relievers, making pain management during emergencies and at the time of surgeries more complicated.
  - o Patients with opioid tolerance must be in clinically significant withdrawal when starting buprenorphine dosing, or they may experience induced withdrawal symptoms and say “the medication made me even sicker.”
  - o There may be limited prescriber availability.
  - o There may be limited insurance coverage.
  - o Some patients may lose their motivation for recovery and stop taking the medication to allow them to return to drug use.
  - o Some OBOT programs may not be able to provide sufficient structure and monitoring to support recovery in some patients.

### **Transitioning patients to opioid agonist treatments: challenges and strategies**

Patients should be advised that addiction treatment is not pain treatment. Patients should not expect full pain relief. Treatment for addiction will likely focus on addiction recovery rather than pain relief. Behavioral treatment will be required, and additional opioid pain medications will likely not be allowed.

There is often no way to directly transfer care or replicate dosing levels. Methadone patients must start from a relatively low dose and gradually build up over time to a stabilizing dose. Patients must be in withdrawal from opioids to initiate buprenorphine treatment.

Communication from the provider to the program will facilitate admission. In particular, it may be helpful for the program to know:

- How the patient meets opioid addiction diagnostic criteria
- Pain treatment history and reasons for referral
- What was being prescribed, as well as the date and quantity of the last prescription.
- If there is a long wait for admission, calls from a referring provider may move the process along.

### **Finding treatment**

- It is helpful to be aware of local resources
- Availability will vary with location and insurance coverage
- Consider creating a resource list for patients
- Consider state treatment locators or hotlines
  - o [ASAM Physician Search](#)
  - o [SAMHSA’s National Drug and Alcohol Treatment Services Locator](#)
- Buprenorphine Treatment
  - o [CSAT Buprenorphine Information Center](#)
  - o [The National Alliance of Advocates for Buprenorphine Treatment](#)



## Treatment Resources

### *Clinician Resources*

- Health Assessments in Primary Care: A How-To Guide for Clinicians and Staff
- [Medication-Assisted Treatment for Opioid Addiction \(Topic in Brief\)](#)
- [Principles of Adolescent Substance Use Disorder Treatment: A Research Based-Guide](#)
- [Principles of Drug Addiction Treatment: A Research-Based Guide, Third Edition](#)
- [Treatment Approaches for Drug Addiction \(NIDA DrugFacts\)](#)

### *Patient Resources*

- [Seeking Drug Abuse Treatment: Know What to Ask](#)
- [Easy-to-Read Drug Facts Web site: Treatment page](#)
- [Treatment Options Fact Sheet](#)

## 5. Hypothetical patient statements

### A. “If you won’t prescribe these, I will just have to buy them on the street”

Options for approaching this challenging statement include:

- Take a breath, count to 10, focus on safety and building a therapeutic relationship
- “I am concerned about you.”
- “I care about your wellbeing and don’t want to see anything bad happen to you.”
- “I am committed to helping you in any way that is safe—please consider these other treatment options that we have discussed.”
- “I hope you won’t do anything that is unsafe or illegal.”
- “Please be aware you could die of an overdose when you take these medications.”
- “Please consider scheduling an appointment with me for the next few weeks so we can check in.”
- “Remember, if you change your mind, you can always come back here and we can work on this together some more.”

### B. “You can’t do this. I’m calling a lawyer.” What are your legal obligations?

References: (Fishbain et al., 2009a; Fishbain et al., 2009b; Mann et al., 2005; McDowell, Lineberry, & Bostwick, 2011)

The legal principle to be aware of in these situations is avoiding “abandonment.”

- Document risk/benefit discussion and why treatment will be/was discontinued
- Allow for medically appropriate taper whenever possible
- Restate commitment to continue to work with patient on pain and addiction if needed
- Refer to specialty pain treatment providers
- Alert patient to addiction treatment resources
- See patient frequently and monitor for progress and safety
- Give copy of discontinuation letter to patient and place copy in chart

### C. “If you stop my medications, I will kill myself.”

References: (Fishbain et al., 2009a; Fishbain et al., 2009b; Mann et al., 2005; McDowell et al., 2011)

- Recognize that mental illness, substance use disorder, a history of suicide attempts, and severe chronic medical conditions are associated with a higher risk of suicide attempts and suicide completion
  - o The absence of risk factors, however, does not indicate a patient is not in danger

- It is recommended that providers ask directly about details of suicidal thoughts and plans to try to establish the patient's level of suicide risk.
  - Having a specific plans and access to a means to commit suicide, especially a firearm, puts patients at higher risk.
- Attention must be paid to the patient's immediate safety. A patient should not be left unattended or in environments where the patient could hurt himself or herself until this issue is resolved (e.g., near open windows, around knives or weapons).
  - If a provider cannot provide a secure environment in the office setting, the help of office security services (if available) or community law enforcement should be obtained.
- Safety contracts, verbal or written, are common but have never been shown to be effective for preventing suicide.

Ultimately, providers must always err on the side of safety. Patients for whom safety cannot be guaranteed must have a comprehensive psychiatric evaluation, which may require an involuntary transport to a facility where emergency psychiatric evaluation can take place. Most offices have policies in place for responding to patients who become acutely unstable in the office. All providers should be aware of regional resources for emergency mental health services.

The steps to initiate mental health involuntary commitments if patients become acutely psychiatrically unstable vary from state to state. All providers should be aware of these steps and have any necessary paperwork on file in the office in case these situations arise.

## **SUPPORTING DOCUMENTS**

This section includes supporting documents for the case study: glossary of terms, commonly used screening instruments, urine drug testing, treating opioid withdrawal symptoms, and a sample notification of discontinuation of opioid treatment letter.

## Glossary of Terms

Please see the Federation of State Medical Boards 2013 publication [\*Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain\*](#) (see section iii, definitions) for a glossary of terms related to chronic opioid therapy and addiction frequently used in this curriculum resource.

## Commonly Used Screening Instruments

### Screening for substance use

<i>Instrument Name</i>	<i>Instrument Description</i>	<i>URL</i>
NIDA Drug Use Screening Tool	Used to identify risky substance use in adult patients	<a href="http://www.drugabuse.gov/nmassist/">http://www.drugabuse.gov/nmassist/</a>
Drug Abuse Screening Test (DAST-10)	Used to assess a patient's drug use, not including alcohol or tobacco use, in the past 12 months	<a href="http://www.drugabuse.gov/sites/default/files/files/DAST-10.pdf">http://www.drugabuse.gov/sites/default/files/files/DAST-10.pdf</a>

### Assessing long-term opioid therapy risks

<i>Instrument Name</i>	<i>Instrument Description</i>	<i>URL</i>
Current Opioid Misuse Measure (COMM)	Determines possible misuse of opioids by patients currently on long-term opioid therapy	<a href="http://nationalpaincentre.mcmaster.ca/documents/comm_sample_watermarked.pdf">http://nationalpaincentre.mcmaster.ca/documents/comm_sample_watermarked.pdf</a>
Opioid Risk Tool (ORT)	Identifies the risk that a patient will misuse opioids prescribed for chronic pain	<a href="http://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf">http://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf</a>
The Screener and Opioid Assessment for Patients with Pain (SOAPP)	Used to plan for long-term opioid therapy for patients with chronic pain, including a patient's risk for developing problems associated with long-term opioid therapy	<a href="http://nhms.org/sites/default/files/Pdfs/SOAPP-14.pdf">http://nhms.org/sites/default/files/Pdfs/SOAPP-14.pdf</a>

### Pain assessment tools

<i>Instrument Name</i>	<i>Instrument Description</i>	<i>URL</i>
Pain Assessment and Documentation Tool (PADT)	Assesses pain-related outcomes and documents long-term pain management over time	<a href="http://www.drugabuse.gov/sites/default/files/files/PainAssessmentDocumentationTool.pdf">http://www.drugabuse.gov/sites/default/files/files/PainAssessmentDocumentationTool.pdf</a>
McCaffrey Initial Pain Assessment Tool	Used to assess a patient's level of pain	<a href="http://www.drugabuse.gov/sites/default/files/files/McCaffreyInitialPainAssessmentTool.pdf">http://www.drugabuse.gov/sites/default/files/files/McCaffreyInitialPainAssessmentTool.pdf</a>

### Screening for Opiate Withdrawal

<i>Instrument Name</i>	<i>Instrument Description</i>	<i>URL</i>
Clinical Opiate Withdrawal Scale (COWS)	Rates common signs and symptoms of opiate withdrawal and helps determine the stage or severity of opiate withdrawal and the level of physical dependence on opioids	<a href="http://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf">http://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf</a>

# Urine Drug Testing: Information for Opioid Prescribers

Reference: Gourlay et al., 2012; Manchikanti et al., 2008; Christo et al., 2011

**Table 2: Comparison of Drug Testing Techniques**

Drug Testing Technique	Characteristics	Advantages	Limitations
Immunoassays	<ul style="list-style-type: none"> <li>Engineered antibodies on elution paper bind to drug metabolites</li> <li>Most commonly used technique, similar to “rapid strep” and over-the-counter (OTC) pregnancy tests</li> </ul>	<ul style="list-style-type: none"> <li>Easy to use in office settings</li> <li>Less expensive than other methods</li> <li>Tests available for specific drugs or a panel of drugs</li> </ul>	<ul style="list-style-type: none"> <li>Qualitative testing, giving a positive or negative result only</li> <li>Often have high cut-off levels, so may give false negative result</li> <li>Often have cross reactivity with other agents, so may give false positive results</li> </ul>
G/LCMS Gas/Liquid Chromatography, Mass Spectrometry	<ul style="list-style-type: none"> <li>Directly and specifically measures drugs or drug metabolites</li> </ul>	<ul style="list-style-type: none"> <li>Very specific, less cross reactivity so minimizes false positives</li> <li>Very sensitive, detects low levels of metabolites, so minimizes false negatives</li> <li>Quantitative testing</li> </ul>	<ul style="list-style-type: none"> <li>Requires specialized laboratory services</li> <li>Very expensive</li> <li>Quantitative levels do not correlate directly with amount of drug taken; levels not reliable for monitoring adherence to prescribed dosing</li> </ul>

**Table 3: Potential Sources of False Positive Immunoassays**

(Selected examples, not a complete list)

Opiates	THC	Amphetamines	PCP
Poppy seeds Dextromethorphan Chlorpromazine Quinolones Rifampin	Efavirenz Proton pump inhibitors (pantoprazole) NSAIDs	OTC decongestants Labetalol Bupropion Ranitidine Trazodone	Venlafaxine Dextromethorphan Chlorpromazine Thioridazine Tramadol

**Table 4: Natural and Synthetic Opioids**

Natural Opioids <i>Found in the opium poppy</i>	Semi-synthetic Opioids <i>Chemically derived from products of opium poppy</i>	Synthetic Opioids <i>Manufactured, not derived from products of opium poppy</i>
Morphine Codeine Thebaine	Hydrocodone Oxycodone Hydromorphone Oxymorphone Buprenorphine Diacetylmorphine (heroin)	Methadone Fentanyl Propoxyphene Meperidine

## Challenges in Testing for Opioids

1. “Opiate” immune assays test for morphine, so only drugs that are metabolized to morphine will show positive on a standard opiate screen.
2. Only morphine, codeine, and heroin are metabolized to morphine. These agents will be reliably detected on a standard opiate immunoassay.
3. All other semi-synthetic and synthetic opioids will show a negative on most standard opiate immunoassays.
4. Immunoassays specifically designed to detect semi-synthetic and synthetic opioids such as oxycodone, buprenorphine, and methadone are available and must be used to test for these agents.
5. A number of opioids have multiple metabolites that occur in small amounts but may give the impression that a patient is taking opioids other than what is being prescribed. Providers must be aware of the potential for multiple metabolites so as not to misinterpret or overinterpret test results.

**Table 5: Metabolites of Commonly Used Opioids**

Opioid Medication	Primary Metabolite	Other Normal Metabolites That May Confuse Results
Heroin	Morphine	6-MAM (monoacetylmorphine)
Codeine	Morphine	Hydrocodone (<10%)
Morphine	Morphine glucuronides Normorphine	Hydromorphone
Hydrocodone	Norhydrocodone	Hydromorphone Dihydrocodeine Normorphine
Oxycodone	Noroxycodone	Oxymorphone
Hydromorphone	Hydromorphone glucuronide	Dihydromorphone

# Treating Opioid Withdrawal Symptoms

## Clonidine: Oral Dosing

- Initial dosing: 0.1 mg po. Watch blood pressure carefully.
- Titrate from 0.1 up to 0.3 mg po q 4-6 hours if tolerated, then taper.
- Risk: Hypotension
- Effective adjuvant to other meds listed.

## Clonidine: Transdermal (patch)

- More steady levels of medication; prevents cyclic hypotension and rebound.
- Dosed one patch per week (\$10/patch).
- Dose range: 0.1 to 0.4 mg.
- 24–48 hours to start to work—can use oral clonidine initially while waiting for effect.

## Analgesics

- NSAIDS: Ibuprofen, Naproxen
- Acetaminophen
- Avoid Tramadol because it is an opioid-like medication.

## Antispasmodics (for abdominal cramping)

- Dicyclomine (Bentyl), 20 mg 4 times daily

## Decongestants

- Pseudoephedrine, 30 to 60 mg 4 times daily
- Phenylephrine, 10 mg 4 times daily

## Antiemetics

- Prochlorperazine (Compazine), 5 to 10 mg 3 times daily
- Promethazine (Phenergan), 25 mg 4 times daily
- Metoclopramide (Reglan), 10 mg 4 times daily

## Muscle relaxants

- Cyclobenzaprine (Flexeril), 5 to 10 mg 3 times daily
- Methocarbamol (Robaxin), 1000 to 1500 mg up to QID
- Do not prescribe SOMA (Carisoprodol): metabolized to a barbiturate and therefore causes physical dependence and risk of withdrawal symptoms when discontinued

## Antidiarrheals

- Kaolin with Pectin
- Bismuth HCL (Pepto-Bismol)
- Loperamide (Imodium)

## Sleep aids

- Diphenhydramine (Benadryl), 50 mg
- Trazodone (Desyrel), 50 to 100 mg
- Amitriptyline (Elavil), 50 mg

## Avoid Benzodiazepines



# **Model Letter: Notification of Discontinuation of Opioid Treatment**

Dear \_\_\_\_\_,

Date: \_\_\_\_\_

Although you are welcome to continue receiving medical treatment in this office, I regret that I will no longer be able to provide opioid treatment for you due to the following circumstances:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Because opioids cause physical dependence when taken regularly, you may experience withdrawal symptoms when you decrease or stop taking the medications. If it is safe to do so, I will provide you with medications for a period of \_\_\_\_\_ weeks to allow you to taper off of these medications. I will also provide non-opioid medications to minimize withdrawal symptoms. Please follow the directions provided to taper off the medications.

To locate addiction treatment services in [Insert State], call [insert phone #].

In [insert region of State], for inpatient detoxification services please call:

- [insert service organization and city] [insert phone #]
- [insert service organization and city] [insert phone #]
- [insert service organization and city] [insert phone #]

For methadone maintenance or buprenorphine treatment, please call:

- [insert methadone maintenance or buprenorphine treatment facility and city] [insert phone #]
- [insert methadone maintenance or buprenorphine treatment facility and city] [insert phone #]
- [insert methadone maintenance or buprenorphine treatment facility and city] [insert phone #]

Sincerely,

## Pain Treatment with Opioid Medications: Sample Patient Agreement\*

I, \_\_\_\_\_, understand and voluntarily agree that  
(initial each statement after reviewing):

\_\_\_\_\_ I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

\_\_\_\_\_ I will participate in all other types of treatment that I am asked to participate in.

\_\_\_\_\_ I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

\_\_\_\_\_ I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

\_\_\_\_\_ I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

\_\_\_\_\_ I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

\_\_\_\_\_ I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

\_\_\_\_\_ I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

\_\_\_\_\_ I will sign a release form to let the doctor speak to all other doctors or providers that I see.

\_\_\_\_\_ I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

\_\_\_\_\_ I will use only one pharmacy to get all on my medicines: \_\_\_\_\_  
Pharmacy name/phone#

\_\_\_\_\_ I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (klonopin, xanax, valium) or stimulants (ritalin, amphetamine) without telling a member of the treatment team **before I fill that prescription**. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

\_\_\_\_\_ I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

\_\_\_\_\_ I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.

\_\_\_\_\_ I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

\_\_\_\_\_ I understand that I may lose my right to treatment in this office if I break any part of this agreement.

### **Pain Treatment Program Statement**

We here at \_\_\_\_\_ are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.

We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.

We will help connect you with other forms of treatment to help you with your condition. We will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.

We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.

If you become addicted to these medications, we will help you get treatment and get off of the medications that are causing you problems safely, without getting sick.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Patient name printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider signature

\_\_\_\_\_  
Provider name printed

\_\_\_\_\_  
Date

\*Adapted from the American Academy of Pain Medicine <http://www.painmed.org/Workarea/DownloadAsset.aspx?id=3203>

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