Partnership™ for Drug-Free Kids
Where families find answers

# What Parents Should Know When Pain Relievers Are Prescribed for Their Children

Used appropriately, medicines can improve our lives. When misused, however, the consequences can be devastating. The overprescribing and misuse of prescription pain relievers has been a major contributor to today's epidemic of opioid addiction and overdose deaths, with four out of five heroin users reporting that they misused prescription opioids before using heroin.

This fact sheet is intended to help parents know what questions to ask when a healthcare provider recommends or prescribes a pain reliever for their child, and how to be sure that their child takes the medication as prescribed without misusing the medication or sharing it with others.

**What are some common opioid pain relievers?**
Hydrocodone (Zohydro)
Hydrocodone + Acetaminophen (Vicodin)
Oxycodone (Oxycontin, Roxicodone)
Oxycodone + Acetaminophen (Percocet)
Codeine, Morphine, Fentanyl, hydromorphone, meperidine

There are also *non*-opioid pain relievers (gabapentin, for example) that also have a certain potential for misuse, but much lower than that of opioids.

**Why the misuse of prescription pain relievers is dangerous**
Opioid pain relievers are powerful drugs -- very similar to heroin in their chemical makeup, and habit forming by their very nature. This is why the U.S. Centers for Disease Control (CDC) strongly recommends against the prescribing of opioids for long-term treatment of chronic pain. Even for treatment of acute (short term) pain, opioid pain relievers should only be prescribed and taken sparingly. The risk of addiction is particularly concerning when the patient is a child or adolescent because their brains are still developing and therefore biologically predisposed to experimentation. So when children and teens are prescribed opioid

pain relievers, parents or caregivers should control the medication, dispense it only as prescribed and monitor their children closely for signs of misuse or growing dependence.

In addition to the danger of dependence, misuse of opioids can cause dramatic changes in blood pressure and heart rate, organ damage, difficulty breathing, seizures and even death.

**Why would a young person be prescribed an opioid pain reliever?**
Opioid pain relievers are most often prescribed following surgery or to treat cancer pain – so many young people will not be in a position to be prescribed opioids. Other situations where opioids may be prescribed for children or teens include: accidental injuries – a sports-related injury, for example, or a biking accident in which a fracture or even a severe sprain occurs. Another reason for which opioids are often prescribed to young people is oral surgery to remove wisdom teeth. Additionally, there are other ailments – sickle cell disease or other pediatric chronic pain conditions – for which opioids may be recommended. It is important to know that over the counter (OTC) pain medications such as acetaminophen (Tylenol) and anti-inflammatory drugs (NSAID) work just as well as opioids for many minor surgeries, accidental injuries and other causes of pain.

**What questions should parents ask their healthcare provider when an opioid pain reliever is recommended or prescribed?**

1. Is a prescription opioid necessary to treat my child's pain? Might an over the counter (OTC) pain reliever such as acetaminophen (e.g., Tylenol), in combination with a non-steroidal anti-inflammatory drug (NSAID) be just as effective? For chronic pain, can we explore alternative treatments such as physical therapy, acupuncture, biofeedback or massage?

2. How many pills are being prescribed, and over how long a period? Is it necessary to prescribe this quantity of pills?

3. What are the risks of misuse? (The prescriber should be able to answer this question for the specific drug being prescribed.)

4. Should my child be screened to determine his/her risk of substance use disorder (SUD) before this medication is prescribed? If not, why not? (Common risk factors include co-occurring mental health disorders such as depression or ADHD, as well as a family history of substance abuse or a recent trauma such as a death in the family or a divorce.)

**What should parents do once an opioid pain reliever has been prescribed for their child?**

1. Safeguard medication at home – i.e., keep the medication in a locked cabinet. Dispose of unused medication at a local "takeback" event or – as an alternative where no takeback opportunities exist -- by mixing the medication with coffee grounds or other unpleasant garbage and throwing it out. Do not hold on to old prescriptions until their expiry date or "in case" they could be needed in the future.

2. As mentioned above, supervise the dispensing of the medication, counting the pills in the bottle to be sure they are being taken as prescribed. Clearly document when the prescription was filled and when a refill will be needed – and be highly suspicious of any missing medication.

3. Communicate with your child about the risks of misuse, and be very clear that the medication is *not* to be shared with others.

4. Communicate regularly with your child about the level of pain he/she is feeling, making sure the pain is diminishing with time and staying alert for any signs that your child is growing dependent on the medication. Make sure that your child understands that he/she might not need to take the full course of the medication if the pain has diminished or gone.

**What signs of misuse or dependence should a parent be alert for?**

1. Signs of misuse can include drowsiness, dizziness, confusion, nausea, constipation, slowed breathing and slurred speech.

2. Parents should be concerned if their child is asking for pain medication more frequently than prescribed, or if he/she is insistent on refilling the prescription. If necessary, the prescriber should be consulted to determine if pain is persisting beyond its expected term.

3. Signs of withdrawal – which would occur if a child has become dependent on an opioid and then stops taking it – include anxiety, irritability, loss of appetite, craving for the drug, runny nose, sweating, vomiting and diarrhea.

If parents are concerned that their child may be dependent on pain medication they should consult the prescriber as soon as possible (who may in turn consult with a pain specialist). If

there is any concern for misuse, parents should consider having a substance use counselor, nurse practitioner or medical doctor take an assessment. An assessment should include a thorough look at the extent of the child's opioid pain reliever, drug and alcohol use, his/her mental and physical health as well as personal, medical and family history.

To learn more about the risks of prescription opioid misuse, and about what parents can do to prevent or get help for a child's substance misuse or abuse, visit the Partnership's Medicine Abuse Project at www.drugfree.org/medicine-abuse-project.org.

Thank you to the following Pediatricians that reviewed this information:

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Patricia Cintra Franco Schram MD, pediatrician specialized in developmental, adolescent, and addiction medicine, Boston Children's Hospital, Harvard Medical School

# PREVENTING AN OPIOID OVERDOSE

# Know the Signs. *Save a Life.*

## Opioid Overdose Basics

Prescription opioids (like hydrocodone, oxycodone, and morphine) and illicit opioids (like heroin and illegally made fentanyl) are powerful drugs that have a risk of a potentially fatal overdose. Anyone who uses opioids can experience an overdose, but certain factors may increase risk including but not limited to:

- Combining opioids with alcohol or certain other drugs
- Taking high daily dosages of prescription opioids
- Taking more opioids than prescribed
- Taking illicit or illegal opioids, like heroin or illicitly-manufactured fentanyl, that could could possibly contain unknown or harmful substances
- Certain medical conditions, such as sleep apnea, or reduced kidney or liver function
- Age greater than 65 years old

Death from an opioid overdose happens when too much of the drug overwhelms the brain and interrupts the body's natural drive to breathe.

Learn more about opioids to protect yourself and your loved ones from opioid abuse, addiction, and overdose: www.cdc.gov/drugoverdose

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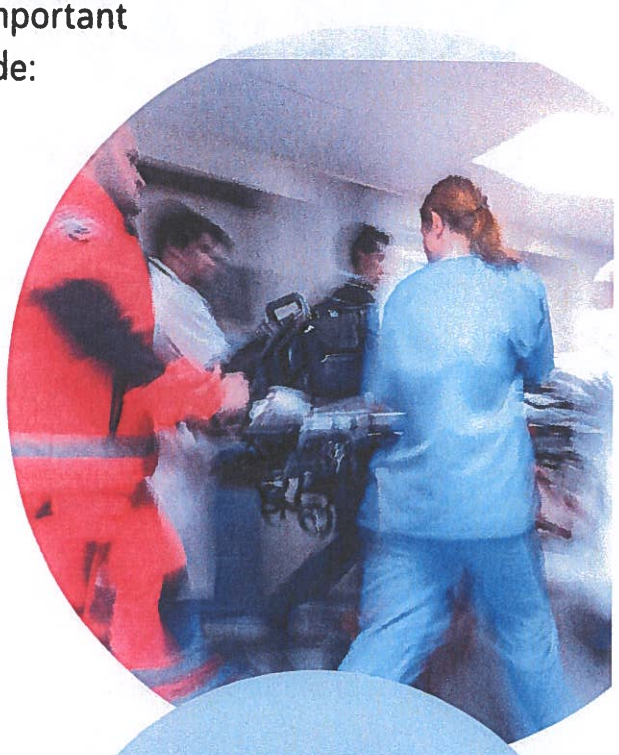
# PREVENTING AN OPIOID OVERDOSE

## Signs and Symptoms of an Opioid Overdose

During an overdose, breathing can be dangerously slowed or stopped, causing brain damage or death. It's important to recognize the signs and act fast. Signs include:

- Small, constricted "pinpoint pupils"
- Falling asleep or loss of consciousness
- Slow, shallow breathing
- Choking or gurgling sounds
- Limp body
- Pale, blue, or cold skin



## What To Do If You Think Someone Is Overdosing

It may be hard to tell if a person is high or experiencing an overdose. If you aren't sure, it's best to treat it like an overdose– you could save a life.

1. Call 911 immediately.
2. Administer naloxone, if available.
3. Try to keep the person awake and breathing.
4. Lay the person on their side to prevent choking.
5. Stay with him or her until emergency workers arrive.

*Ask your doctor about naloxone - a safe medication that can quickly stop an opioid overdose. It can be injected into the muscle or sprayed into the nose to rapidly block the effects of the opioid on the body.*

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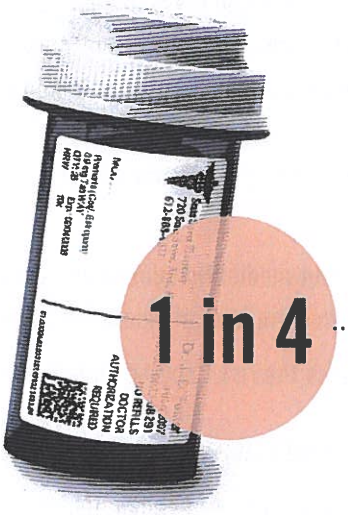
# PROMOTING SAFER AND MORE EFFECTIVE PAIN MANAGEMENT

## UNDERSTANDING PRESCRIPTION OPIOIDS

Opioids are natural or synthetic chemicals that relieve pain by binding to receptors in your brain or body to reduce the intensity of pain signals reaching the brain. Opioid pain medications are sometimes prescribed by doctors to treat pain. Common types include:

- Hydrocodone (e.g., Vicodin)
- Oxycodone (e.g., OxyContin)
- Oxymorphone (e.g., Opana), and
- Morphine

***Opioids can have serious risks including addiction and death from overdose.***




As many as 1 in 4 people receiving prescription opioids long term in a primary care setting struggles with addiction.


Americans engaged in non-medical use of opioid pain medication in the last month.[1]

[1] National Survey on Drug Use and Health (NSDUH) 2014

## OPIOIDS AND CHRONIC PAIN

Many Americans suffer from chronic pain, a major public health concern in the United States. Patients with chronic pain deserve safe and effective pain management. At the same time, our country is in the midst of a prescription opioid overdose epidemic.

- The amount of opioids prescribed and sold in the US quadrupled since 1999, but the overall amount of pain reported hasn't changed.
- There is insufficient evidence that prescription opioids control chronic pain effectively over the long term, and there is evidence that other treatments can be effective with less harm.

# PRESCRIPTION OPIOID OVERDOSE IS AN EPIDEMIC IN THE US

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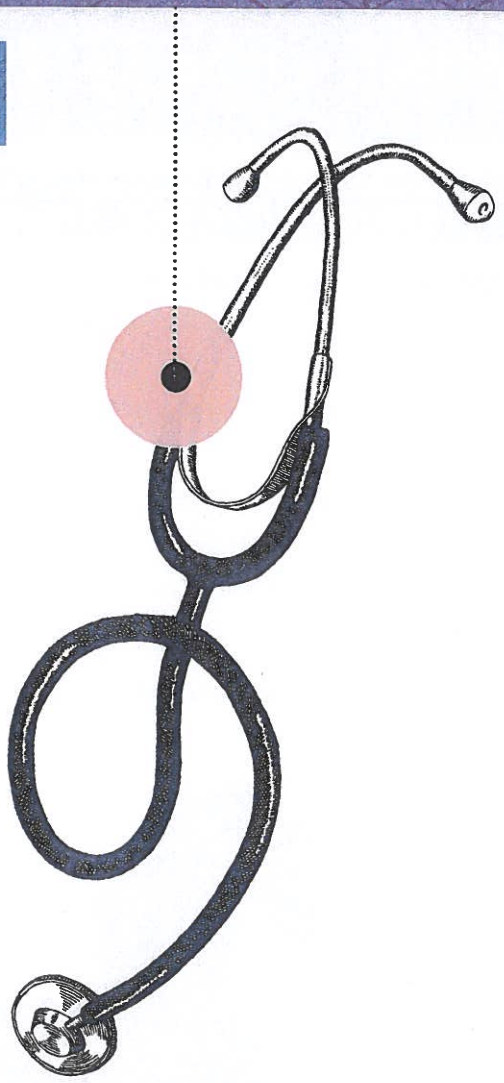
**LEARN MORE** | www.cdc.gov/drugoverdose/prescribing/guideline.html

## IMPROVE DOCTOR AND PATIENT COMMUNICATION

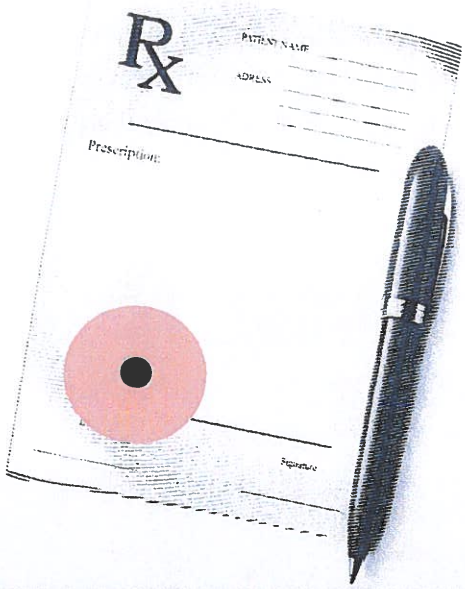


The Centers for Disease Control and Prevention's (CDC) *Guideline for Prescribing Opioids for Chronic Pain* provides recommendations to primary care doctors about the appropriate prescribing of opioid pain medications to improve pain management and patient safety:

- It helps primary care doctors determine when to start or continue opioids for chronic pain
- It gives guidance about medication dose and duration, and on following up with patients and discontinuing medication if needed
- It helps doctors assess the risks and benefits of using opioids

**Doctors and patients should talk about:**

- How opioids can reduce pain during short-term use, yet there is not enough evidence that opioids control chronic pain effectively long term
- Nonopioid treatments (such as exercise, nonopioid medications, and cognitive behavioral therapy) that can be effective with less harm
- Importance of regular follow-up
- Precautions that can be taken to decrease risks including checking drug monitoring databases, conducting urine drug testing, and prescribing naloxone if needed to prevent fatal overdose
- Protecting your family and friends by storing opioids in a secure, locked location and safely disposing unused opioids



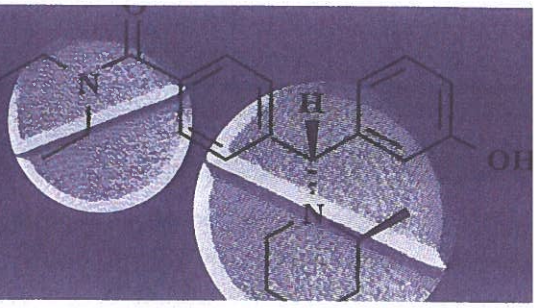

## GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

CDC developed the *Guideline for Prescribing Opioids for Chronic Pain* to:

- Help reduce misuse, abuse, and overdose from opioids
- Improve communication between primary care doctors and patients about the risks and benefits of opioid therapy for chronic pain

**LEARN MORE** | www.cdc.gov/drugoverdose/prescribing/guideline.html

# PRESCRIPTION OPIOIDS: WHAT YOU NEED TO KNOW



Prescription opioids can be used to help relieve moderate-to-severe pain and are often prescribed following a surgery or injury, or for certain health conditions. These medications can be an important part of treatment but also come with serious risks. It is important to work with your health care provider to make sure you are getting the safest, most effective care.

## WHAT ARE THE RISKS AND SIDE EFFECTS OF OPIOID USE?

**Prescription opioids carry serious risks of addiction and overdose, especially with prolonged use.** An opioid overdose, often marked by slowed breathing, can cause sudden death. The use of prescription opioids can have a number of side effects as well, even when taken as directed:

- Tolerance—meaning you might need to take more of a medication for the same pain relief
- Physical dependence—meaning you have symptoms of withdrawal when a medication is stopped
- Increased sensitivity to pain
- Constipation
- Nausea, vomiting, and dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Low levels of testosterone that can result in lower sex drive, energy, and strength
- Itching and sweating

As many as **1 in 4** PEOPLE*

receiving prescription opioids long term in a primary care setting struggles with addiction.

* Findings from one study

## RISKS ARE GREATER WITH:

- History of drug misuse, substance use disorder, or overdose
- Mental health conditions (such as depression or anxiety)
- Sleep apnea
- Older age (65 years or older)
- Pregnancy

Avoid alcohol while taking prescription opioids. Also, unless specifically advised by your health care provider, medications to avoid include:

- Benzodiazepines (such as Xanax or Valium)
- Muscle relaxants (such as Soma or Flexeril)
- Hypnotics (such as Ambien or Lunesta)
- Other prescription opioids

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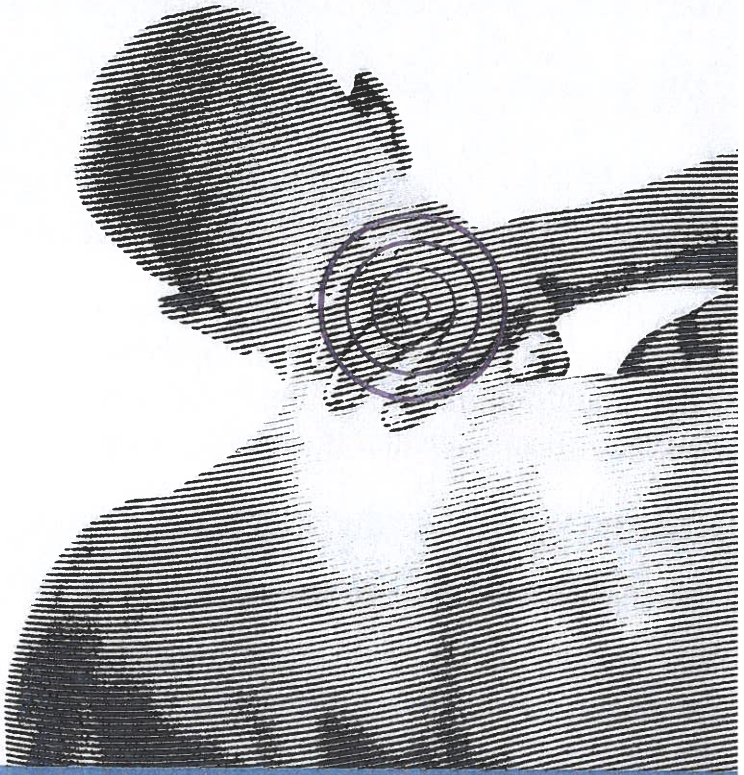
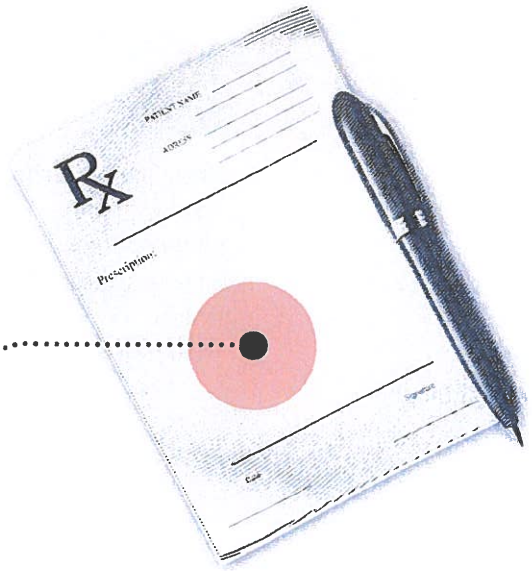
## KNOW YOUR OPTIONS

Talk to your health care provider about ways to manage your pain that don't involve prescription opioids. Some of these options **may actually work better** and have fewer risks and side effects. Options may include:

- ☐ Pain relievers such as acetaminophen, ibuprofen, and naproxen
- ☐ Some medications that are also used for depression or seizures
- ☐ Physical therapy and exercise
- ☐ Cognitive behavioral therapy, a psychological, goal-directed approach, in which patients learn how to modify physical, behavioral, and emotional triggers of pain and stress.






### Be Informed!

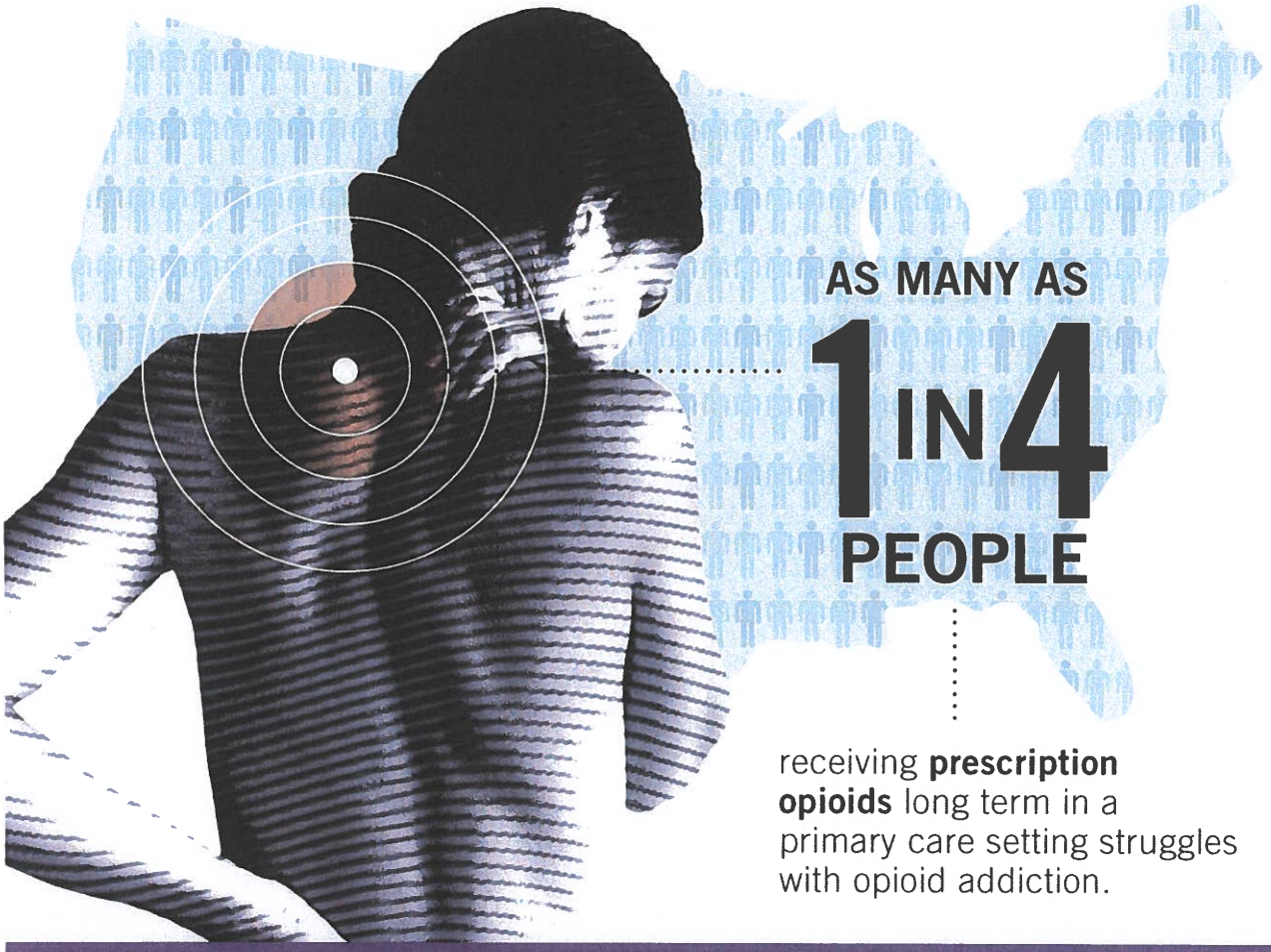
Make sure you know the name of your medication, how much and how often to take it, and its potential risks & side effects.

## IF YOU ARE PRESCRIBED OPIOIDS FOR PAIN:

- ☐ Never take opioids in greater amounts or more often than prescribed.
- ☐ Follow up with your primary health care provider within ___ days.
  - Work together to create a plan on how to manage your pain.
  - Talk about ways to help manage your pain that don't involve prescription opioids.
  - Talk about any and all concerns and side effects.
- ☐ Help prevent misuse and abuse.
  - Never sell or share prescription opioids.
  - Never use another person's prescription opioids.
- ☐ Store prescription opioids in a secure place and out of reach of others (this may include visitors, children, friends, and family).
- ☐ Safely dispose of unused prescription opioids: Find your community drug take-back program or your pharmacy mail-back program, or flush them down the toilet, following guidance from the Food and Drug Administration (www.fda.gov/Drugs/ResourcesForYou).
- ☐ Visit www.cdc.gov/drugoverdose to learn about the risks of opioid abuse and overdose.
- ☐ If you believe you may be struggling with addiction, tell your health care provider and ask for guidance or call SAMHSA's National Helpline at 1-800-662-HELP.

**LEARN MORE** | www.cdc.gov/drugoverdose/prescribing/guideline.html

# KNOW THE RISKS



**AS MANY AS**

**1 IN 4**

**PEOPLE**

receiving **prescription opioids** long term in a primary care setting struggles with opioid addiction.

## MANAGE YOUR PAIN, MINIMIZE YOUR RISK.

Chronic pain can be devastating, and effective pain management is essential to get your life back. Talk to your doctor about ways to manage your pain that don't involve prescription opioids, such as:

- Non-opioid pain relievers, such as acetaminophen (Tylenol®), ibuprofen (Advil®), or naproxen (Aleve®)
- Physical therapy and exercise
- Cognitive behavioral therapy
- Certain antidepressants and anticonvulsants

**GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN**

**LEARN MORE** | www.cdc.gov/drugoverdose/prescribing.guideline.html

OPIOIDS FOR ACUTE PAIN

# Get the Facts

## Short Term Use

**FACT**

After taking opioids for just 5 days in a row, a person becomes more likely to take them long-term.[1]

**Opioids can be addictive even if only taken for a short period of time.**

## Level of Pain Relief

**FACT**

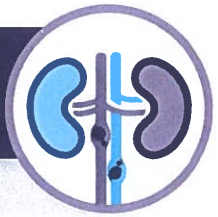
Opioids provide an average of 20-30% pain relief when used for pain lasting less than three months. Options that do not involve opioids may provide enough pain relief while avoiding the risks of opioids.[2]

**Opioids don't take away pain completely.**

## Kidney Stone Pain

**FACT**

Nonsteroidal anti-inflammatory drugs (NSAIDs), like ibuprofen and naproxen, work just as well as opioids (and sometimes better) for kidney stone pain.[3]



**Opioids aren't the only treatment for acute pain from kidney stones.**

## Back Pain Relief

**FACT**

Naproxen taken alone relieves acute low back pain and improves function just as well as when it is combined with an opioid or muscle relaxer.[4]

**Opioids aren't the most effective treatment for acute low back pain.**

## Healing From a Broken Bone

**FACT**

After a minor fracture, nonsteroidal anti-inflammatory drugs (NSAIDs), like ibuprofen and naproxen, provide adequate pain and relief and allow bones to heal, without introducing the risks side effects of opioids.[5] As with any medicine, NSAIDs have side effects. Doctors can offer the safest, most appropriate and effective care for their patients.

**Bones can heal properly after fractures, even when taking NSAIDs for pain.**


**1.** Shah A, Hayes CJ, Martin BC. Characteristics of initial prescription episodes and likelihood of long-term opioid use - United States, 2006-2015. MMWR. 2017 Mar 17;66 (10):265-269. **2.** Furlan AD, Sandoval JA, Mailis-Gagnon A, et al. Opioids for chronic noncancer pain: a meta-analysis of effectiveness and side effects. CMAJ. 2006;174: 1589-1594. **3.** Teichman JM. Clinical practice. Acute renal colic from ureteral calculus. N Engl J Med. 2004; 350(7):684. Holdgate A, Pollock T. Systematic review of the relative efficacy of non-steroidal anti-inflammatory drugs and opioids in the treatment of acute renal colic. BMJ. 2004;328(7453):1401. **4.** Friedman BW, Dym AA, Davitt M, et al. naproxen with cyclobenzaprine, oxycodone/acetaminophen, or placebo for treating acute low back pain: a randomized clinical trial. JAMA. 2015 Oct 20;314(15):1572-80. **5.** Solomon DH, MD, MPH. Nonselective NSAIDs: Overview of adverse effects. UpToDate. Sep 20, 2016. Dodwell ER, Latorre JG, Parisini E, et al. NSAID exposure and risk of nonunion: a meta-analysis of case-control and cohort studies. Calcif Tissue Int. 2010;87(3):193.



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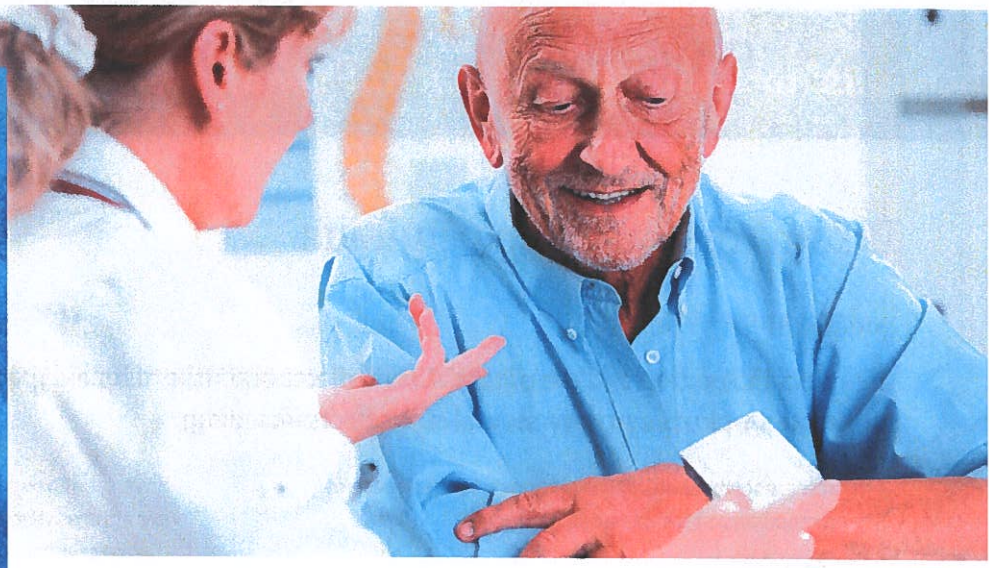
Learn More: www.cdc.gov/drugoverdose

Opioids for Acute Pain

# What You Need to Know



## Types of Pain

Acute pain usually occurs suddenly and has a known cause, like an injury, surgery, or infection. You may have experienced acute pain, for example, from a wisdom tooth extraction, an outpatient medical procedure, or a broken arm after a car crash. Acute pain normally resolves as your body heals. Chronic pain, on the other hand, can last weeks or months–past the normal time of healing.

## Prescription Opioids

Prescription opioids (like hydrocodone, oxycodone, and morphine) are one of the many options for treating severe acute pain. While these medications can reduce pain during short-term use, they come with serious risks including addiction and death from overdose when taken for longer periods of time or at high doses.

### Acute pain can be managed without opioids

Ask your doctor about ways to relieve your pain that do not involve prescription opioids. These treatments may actually work better and have fewer risks and side effects.

Ask your doctor about your options and what level of pain relief and improvement you can expect for your acute pain.

**Nonopioid options include:**

*Pain relievers like ibuprofen, naproxen, and acetaminophen*

*Acupuncture or massage*

*Application of heat or ice*

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Learn More: www.cdc.gov/drugoverdose

# If You Are Prescribed Opioids

## Know your risks

**It is critical to understand the potential side effects and risks of opioid pain medications. Even when taken as directed, opioids can have several side effects including:**

- Tolerance, meaning you might need to take more of a medication for the same pain relief
- Constipation
- Nausea and vomiting
- Dry mouth
- Sleepiness and dizziness
- Physical dependence, meaning you have withdrawal symptoms when a medication is stopped–this can develop within a few days
- Confusion
- Depression
- Itching

## Know what to expect from your doctor

**If your doctor is prescribing opioids for acute pain, you can expect him or her to protect your safety in some of the following ways. Your provider may:**

- Prescribe the lowest effective dose of immediate-release opioids
- Prescribe treatment for 3 days or less, which is usually enough for most acute conditions
- Ask you to follow up if your pain is not resolving as quickly as expected
- Check your state's prescription drug monitoring program
- Conduct urine drug testing during the course of your therapy
- Provide instructions on how to taper opioids to minimize withdrawal symptoms

## Know your responsibilities

**It is critical to know exactly how much and how often to take the opioid pain medications you are prescribed, as well as how to safely store and dispose of them.**

- Never take opioids in higher amounts or more often than prescribed
- Do not combine opioids with alcohol or other drugs that cause drowsiness, such as:
  - *Benzodiazepines, also known as "benzos" including diazepam and alprazolam*
  - *Muscle relaxants*
  - *Sleep aids*
- Never sell or share prescription opioids
- Store opioids in a secure place and out of reach of others (including children, family, friends, and visitors)
- If you have unused opioids at the end of your treatment:
  - *Find your community drug take-back program,*
  - *Find your pharmacy mail-back program, or*
  - *Flush them down the toilet following guidance from the Food and Drug Administration: https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm101653.htm*

# CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

## Promoting Patient Care and Safety

## THE US OPIOID OVERDOSE EPIDEMIC

The United States is in the midst of an epidemic of prescription opioid overdoses. The amount of opioids prescribed and sold in the US quadrupled since 1999, but the overall amount of pain reported by Americans hasn't changed. This epidemic is devastating American lives, families, and communities.

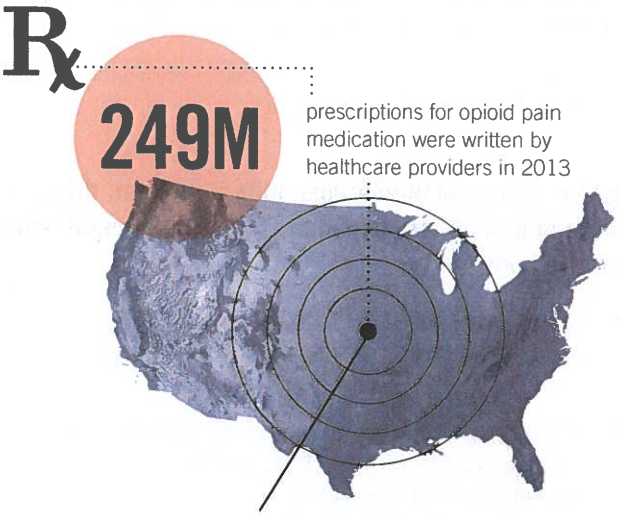

More than 40 people die every day from overdoses involving prescription opioids.[1]


Since 1999, there have been over 165,000 deaths from overdose related to prescription opioids.[1]


4.3 million Americans engaged in non-medical use of prescription opioids in the last month.[2]

## PRESCRIPTION OPIOIDS HAVE BENEFITS AND RISKS

Many Americans suffer from chronic pain. These patients deserve safe and effective pain management. Prescription opioids can help manage some types of pain in the short term. However, we don't have enough information about the benefits of opioids long term, and we know that there are serious risks of opioid use disorder and overdose—particularly with high dosages and long-term use.




**enough prescriptions were written for every American adult to have a bottle of pills**

[1] Includes overdose deaths related to methadone but does not include overdose deaths related to other synthetic prescription opioids such as fentanyl.

[2] National Survey on Drug Use and Health (NSDUH), 2014

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**LEARN MORE** | www.cdc.gov/drugoverdose/prescribing/guideline.html

# NEW CDC GUIDELINE WILL HELP IMPROVE CARE, REDUCE RISKS

**The Centers for Disease Control and Prevention (CDC) developed the *CDC Guideline for Prescribing Opioids for Chronic Pain* (Guideline) for primary care clinicians treating adult patients for chronic pain in outpatient settings. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care. The Guideline was developed to:**

- Improve communication between clinicians and patients about the benefits and risks of using prescription opioids for chronic pain
- Provide safer, more effective care for patients with chronic pain
- Help reduce opioid use disorder and overdose

**The Guideline provides recommendations to primary care clinicians about the appropriate prescribing of opioids to improve pain management and patient safety. It will:**

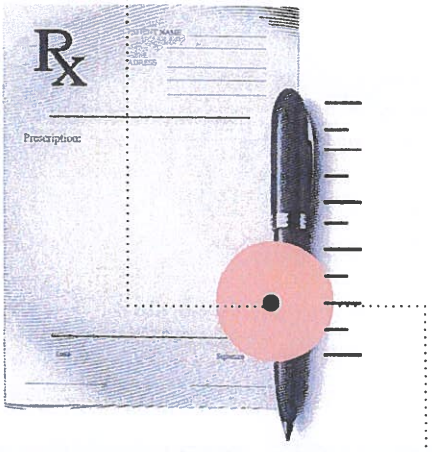
- Help clinicians determine if and when to start prescription opioids for chronic pain
- Give guidance about medication selection, dose, and duration, and when and how to reassess progress, and discontinue medication if needed
- Help clinicians and patients—together—assess the benefits and risks of prescription opioid use

**Among the 12 recommendations in the Guideline, there are three principles that are especially important to improving patient care and safety:**

- ✔ Nonopioid therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care.
- ✔ When opioids are used, the lowest possible effective dosage should be prescribed to reduce risks of opioid use disorder and overdose.
- ✔ Clinicians should always exercise caution when prescribing opioids and monitor all patients closely.

To develop the Guideline, CDC followed a transparent and rigorous scientific process using the best available scientific evidence, consulting with experts, and listening to comments from the public and partners.


patients receiving long-term **opioid therapy** in primary care settings




struggle with **opioid use disorder.**

## PATIENT CARE AND SAFETY IS CENTRAL TO THE GUIDELINE

**Before starting opioids to treat chronic pain, patients should:**

- Make the most informed decision with their doctors
- Learn about prescription opioids and know the risks
- Consider ways to manage pain that do not include opioids, such as:
  - Physical therapy
  - Exercise
  - Nonopioid medications, such as acetaminophen or ibuprofen
  - Cognitive behavioral therapy (CBT)

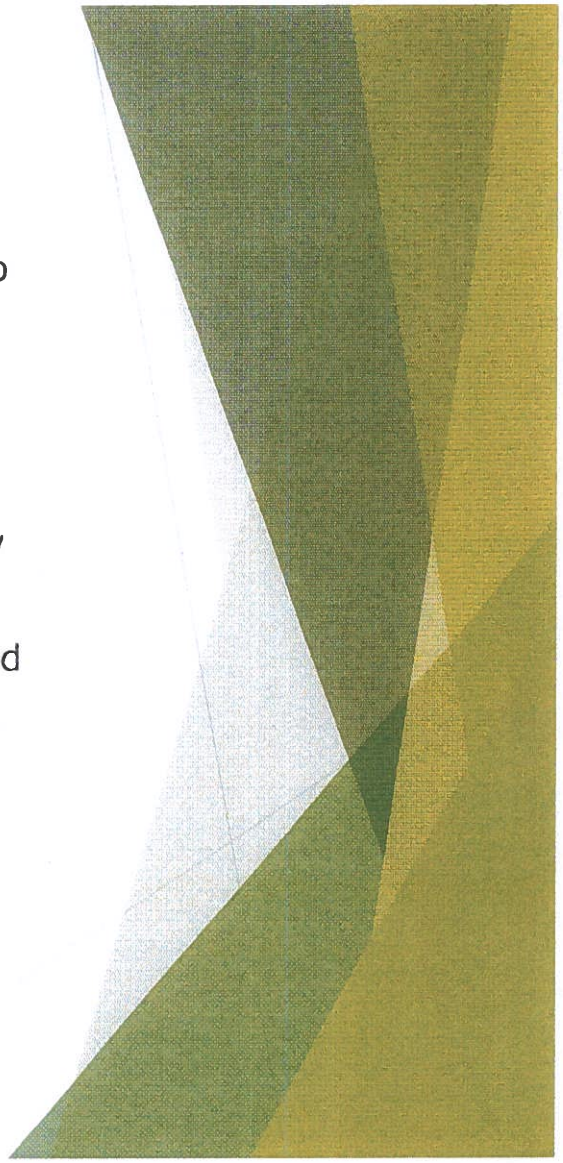
**LEARN MORE** | www.cdc.gov/drugoverdose/prescribing/guideline.html

# Signs of Opioid Use Disorder

What you should know

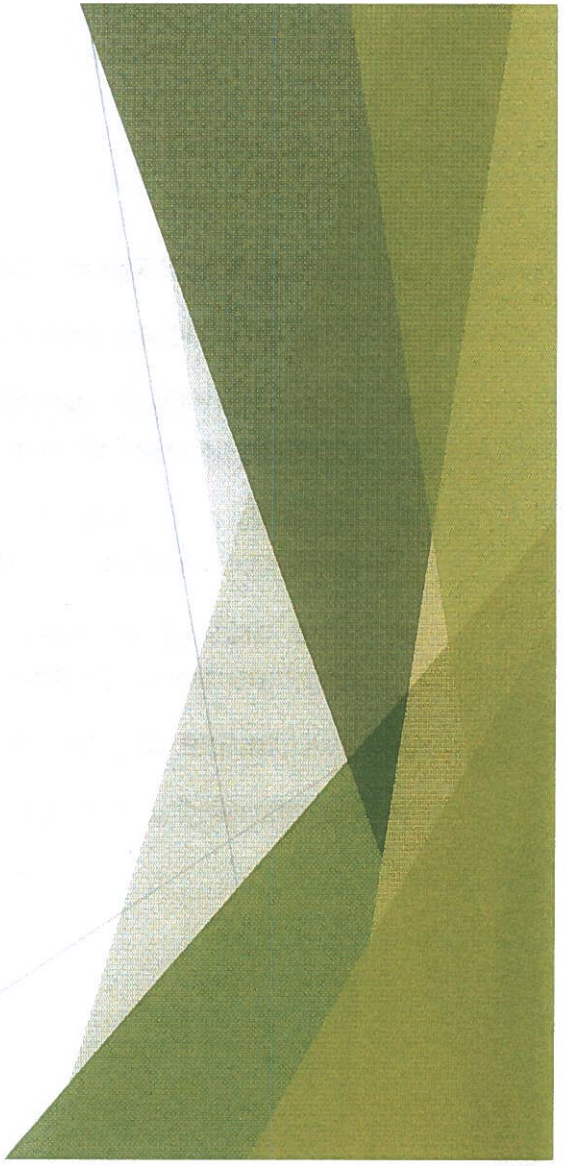
# What you need to know

- More than 210 Million Opiate Prescriptions were filled in 2010, with close to 12 million people admitting to abusing these drugs by taking them for non-medical reasons
- Per the CDC, certain studies reveal that as many as three out of every four current heroin users were previously prescription opiate abusers
- The amount of painkillers prescribed in 2010 was enough to medicate every American 24 hours a day for one month
- Deaths from Opiate Painkillers outnumber deaths from illicit drugs combined
- According to the CDC, currently 174 people die every day in the US from an accidental drug overdose
- Our nation is suffering from a public health crisis



# Psychological/Mood Symptoms

- Continued use despite knowing it is leading to or worsening a psychological problem
- Euphoria
- Anxiety
- Confusion
- Poor judgement
- Inability to make decisions
- Inability to plan
- Poor concentration or attention
- Memory problems



# Behavioral

- Opiates are taken for longer or at higher doses
- The individual unsuccessfully tries to cut down on the amount used
- The individual spends a lot of time obtaining, using or dealing with the consequences of the opioid
- Opioids restricts the individual's ability to meet their responsibilities in different areas of life
- The individual does not stop using the drug despite knowing it is causing interpersonal problems
- Avoidance of previously important activities
- Continued use in situations which could be hazardous

# Physiological

- Cravings for the drug
- Sleepiness or sedation
- Numbness or inability to feel pain
- Depressed respirations
- Small pupils
- Nausea or vomiting
- Itching
- Rashes or flushed skin
- Constipation
- Slurred speech
- The development of tolerance
  - Needing more of the drug to achieve desired effect
  - When taking the same amount the effects of the drug diminish over time
- Withdrawal symptoms with no longer taking the drug or decreasing the dose
- Drug is taken to avoid withdrawal symptoms

# Ways to Prevent Exposure and Opiate Use Disorder

- Prescription drug monitoring programs
  - OARRS
  - CDC prescribing guidelines
- State Prescription Laws
  - www.cdc.gov/drugoverdose/policy/laws.html
- Formulary management strategies in insurance programs, such as prior authorization, quantity limits, and drug utilization review

# Ways to Prevent Exposure and Opiate Use Disorder

- Academic detailing to educate providers about opioid prescribing guidelines and facilitating conversations with patients about the risks and benefits of pain treatment options
- Quality improvement programs in health care systems to increase implementation of recommended prescribing practices

# Ways to Prevent Exposure and Opiate Use Disorder

- Patient education on the safe storage and disposal of prescription opioids
- Improve awareness and share resources about the risks of prescription opioids, and the cost of overdose on patient and families
  - See CDC's Rx Awareness
    - www.cdc.gov/rxawareness/index.html

# References

www.cdc.gov/drugoverdose/prevention/opioid-use-disorder.html

# Alternative Pain Management

# Principles of Chronic Pain Treatment

- Patients with pain should receive treatment that provides the greatest benefit.
- Evidence suggests that non-opioid treatments, including non-opioid medications and nonpharmacological therapies can provide relief.

# EFFECTIVE APPROACHES TO CHRONIC PAIN SHOULD BE:

- Use non-opioid therapies to the extent possible
- Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)
- Focus on functional goals and improvement, engaging patients actively in their pain management
- Use disease-specific treatments when available (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine for neuropathic pain)
- Use first-line medication options preferentially
- Consider interventional therapies (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies
- Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors

# Non-Opioid Medications

| Medication | Magnitude of Benefits | Harms | Comments |
|---|---|---|---|
| Acetaminophen | Small | Hepatotoxic, particularly at higher doses | First-line analgesic, probably less effective than NSAIDs |
| NSAIDs | Small-Moderate | Cardiac, GI, Renal | First-line analgesic, COX-2 selective NNSAIDs less GI toxicity |
| Gabapentin/pregabalin | Small-Moderate | Sedation, dizziness, ataxia | First-line agent for neuropathic pain; pregabalin approved for fibromyalgia |
| Tricyclic antidepressants and serotonin/norepinephrine reuptake inhibitors | Small-Moderate | TCAs have anticholinergic and cardiac toxicities; SNRIs safer and better tolerated | First-line agent for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches |
| Topical agents (lidocaine, capsaicin, NSAIDs) | Small-Moderate | Capsaicin initial flare/burning, irritation of mucus membranes | Consider as alternative first-line, thought to be safer than systemic medications. Lidocaine for neuropathic pain, topical NSAIDs for localized osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain |

# Recommended Treatments for Common Chronic Pain Conditions

# Low Back Pain

- **Self-care and education in all patients;** Advise patients to remain active and limit bedrest
- **Nonpharmacological treatments:** Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation
- **Medications**
  - First-line: Non-steroidal anti-inflammatory drugs (NSAIDs)
  - Second-line: Serotonin and norepinephrine reuptake inhibitors (SNRIs)/Tricyclic antidepressants (TCAs)

# OSTEOARTHRITIS

- **Nonpharmacological treatments:** Exercise, weight loss, patient education
- **Medications**
  - First-line: Acetaminophen, oral NSAIDs, topical NSAIDs
  - Second-line: Intra-articular hyaluronic acid, capsaicin (limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs insufficient

# Migraine

- **Preventative Treatments**
  - Beta-blockers
  - TCAs
  - Anti-seizure medications
  - Calcium channel blockers
  - Non-pharmacological treatments (cognitive behavioral therapy, relaxation, biofeedback, exercise therapy)
  - Avoid Triggers
- **Acute Treatments**
  - Aspirin, acetaminophen, NSAIDs (may be combined with caffeine)
  - Anti-nausea medication
  - Triptans-migraine-specific

# FIBROMYALGIA

- **Patient Education:** Address diagnosis, treatment and the patient's role in treatment
- **Nonpharmacological treatments:** Low-impact aerobic exercise (e.g., brisk walking, swimming, water aerobics, or bicycling)
- **Medications**
  - FDA-approved: Pregabalin, duloxetine, milnacipran
  - Other options: TCAs, gabapentin

# Neuropathic Pain

- Medications: TCAs, SNRIs, gabapentin/pregabalin, topical lidocaine

# References

www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf

# Opioid Risk Tool

## Introduction

The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behavior. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations.

# Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

| Mark each box that applies | Female | Male |
|---|---|---|
| **Family history of substance abuse** | | |
| Alcohol | 1 | 3 |
| Illegal drugs | 2 | 3 |
| Rx drugs | 4 | 4 |
| **Personal history of substance abuse** | | |
| Alcohol | 3 | 3 |
| Illegal drugs | 4 | 4 |
| Rx drugs | 5 | 5 |
| **Age between 16—45 years** | 1 | 1 |
| **History of preadolescent sexual abuse** | 3 | 0 |
| **Psychological disease** | | |
| ADD, OCD, bipolar, schizophrenia | 2 | 2 |
| Depression | 1 | 1 |
| **Scoring totals** | | |

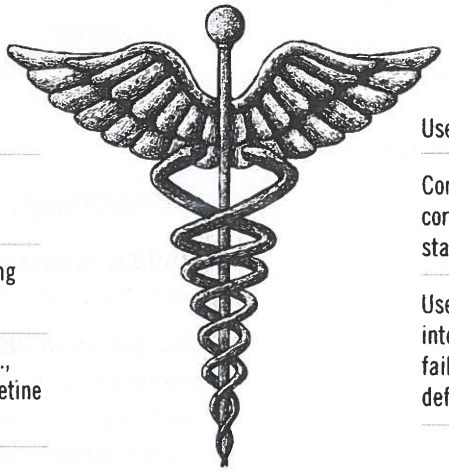
Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

# NONOPIOID TREATMENTS FOR CHRONIC PAIN

## PRINCIPLES OF CHRONIC PAIN TREATMENT

Patients with pain should receive treatment that provides the greatest benefit. Opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that nonopioid treatments, including nonopioid medications and nonpharmacological therapies can provide relief to those suffering from chronic pain, and are safer. Effective approaches to chronic pain should:



- Use nonopioid therapies to the extent possible
- Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)
- Focus on functional goals and improvement, engaging patients actively in their pain management
- Use disease-specific treatments when available (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine for neuropathic pain)
- Use first-line medication options preferentially
- Consider interventional therapies (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies
- Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors

## NONOPIOID MEDICATIONS

| MEDICATION | MAGNITUDE OF BENEFITS | HARMS | COMMENTS |
|---|---|---|---|
| Acetaminophen | Small | Hepatotoxic, particularly at higher doses | First-line analgesic, probably less effective than NSAIDs |
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LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

CS263451 April 27, 2016

# RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

## Low back pain

**Self-care and education in all patients;** advise patients to remain active and limit bedrest

**Nonpharmacological treatments:** Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation

**Medications**

- First-line: acetaminophen, non-steroidal anti inflammatory drugs (NSAIDs)
- Second-line: Serotonin and norepinephrine reuptake inhibitors (SNRIs)/tricyclic antidepressants (TCAs)

## Migraine

**Preventive treatments**

- Beta-blockers
- TCAs
- Antiseizure medications
- Calcium channel blockers
- Non-pharmacological treatments (Cognitive behavioral therapy, relaxation, biofeedback, exercise therapy)
- Avoid migraine triggers

**Acute treatments**

- Aspirin, acetaminophen, NSAIDs (may be combined with caffeine)
- Antinausea medication
- Triptans-migraine-specific

## Neuropathic pain

**Medications:** TCAs, SNRIs, gabapentin/pregabalin, topical lidocaine

## Osteoarthritis

**Nonpharmacological treatments:** Exercise, weight loss, patient education

**Medications**

- First-line: Acetamionphen, oral NSAIDs, topical NSAIDs
- Second-line: Intra-articular hyaluronic acid, capsaicin (limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs insufficient)

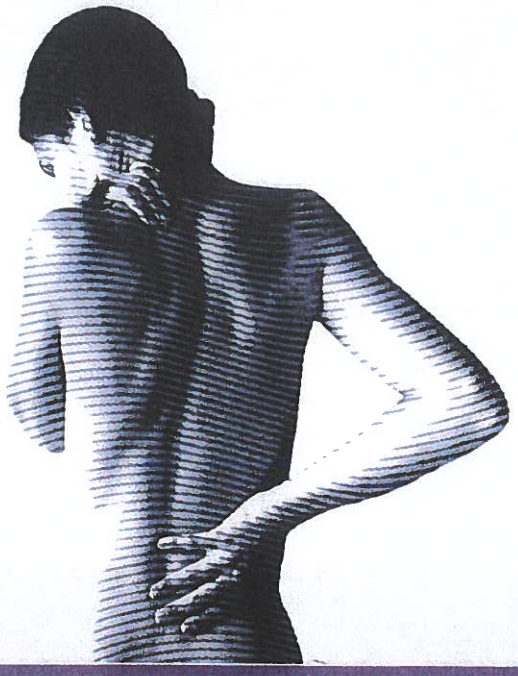
## Fibromyalgia

**Patient education:** Address diagnosis, treatment, and the patient's role in treatment

**Nonpharmacological treatments:** Low-impact aerobic exercise (e.g., brisk walking, swimming, water aerobics, or bicycling), cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation

**Medications**

- FDA-approved: Pregabalin, duloxetine, milnacipran
- Other options: TCAs, gabapentin



LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

# CDC RECOMMENDATIONS

## DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

### 1 OPIOIDS ARE NOT FIRST-LINE THERAPY

**Nonpharmacologic therapy** and **nonopioid pharmacologic therapy** are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

**Nonpharmacologic therapies and nonopioid medications include:**

- Nonopioid medications such as acetaminophen, ibuprofen, or certain medications that are also used for depression or seizures
- Physical treatments (eg, exercise therapy, weight loss)
- Behavioral treatment (eg, CBT)
- Interventional treatments (eg, injections)

### 2 ESTABLISH GOALS FOR PAIN AND FUNCTION

Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

### 3 DISCUSS RISKS AND BENEFITS

Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

## OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

### 4 USE IMMEDIATE-RELEASE OPIOIDS WHEN STARTING

When starting opioid therapy for chronic pain, clinicians should prescribe **immediate-release opioids** instead of extended-release/long-acting (ER/LA) opioids.

**Immediate-release opioids:** faster acting medication with a shorter duration of pain-relieving action

**Extended release opioids:** slower acting medication with a longer duration of pain-relieving action

### 5 USE THE LOWEST EFFECTIVE DOSE

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 **morphine milligram equivalents (MME)/day**, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

**Morphine milligram equivalents (MME)/day:** the amount of morphine an opioid dose is equal to when prescribed, often used as a gauge of the abuse and overdose potential of the amount of opioid that is being given at a particular time

### 6 PRESCRIBE SHORT DURATIONS FOR ACUTE PAIN

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

**LEARN MORE** | www.cdc.gov/drugoverdose/prescribing/guideline.html

### 7 EVALUATE BENEFITS AND HARMS FREQUENTLY

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

## ASSESSING RISK AND ADDRESSING HARMS

### 8 USE STRATEGIES TO MITIGATE RISK

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering **naloxone** when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent **benzodiazepine** use, are present.

**Naloxone:** a drug that can reverse the effects of opioid overdose

**Benzodiazepine:** sometimes called "benzo," is a sedative often used to treat anxiety, insomnia, and other conditions

### 9 REVIEW PDMP DATA

Clinicians should review the patient's history of controlled substance prescriptions using state **prescription drug monitoring program (PDMP)** data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

**PDMP:** a prescription drug monitoring program is a statewide electronic database that tracks all controlled substance prescriptions

### 10 USE URINE DRUG TESTING

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.


**Americans, aged 12 or older, either abused or were dependent on prescription opioids in 2014**

### 11 AVOID CONCURRENT OPIOID AND BENZODIAZEPINE PRESCRIBING

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

### 12 OFFER TREATMENT FOR OPIOID USE DISORDER

Clinicians should offer or arrange evidence-based treatment (usually **medication-assisted treatment** with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

**Medication-assisted treatment:** treatment for opioid use disorder including medications such as buprenorphine or methadone

# Acute Pain Prescribing Guidelines

A companion to Ohio's Guidelines for the Management of Acute Pain Outside of Emergency Departments

*These guidelines are to be used as a clinical tool, but they do not replace clinician judgment.*

## Patient Presents with Acute Pain

### 1 Pain Assessment:

- Medical history and physical examination, including pregnancy status
- Location, intensity, severity; and associated symptoms
- Quality of pain (somatic, visceral or neuropathic)
- Psychological factors, personal/family history of addiction

### 2 Develop a Plan:

- Educate patient and family and negotiate goals of treatment
- Discuss risks/benefits of non-pharmacologic & pharmacologic therapies
- Set patient expectations for the degree and the duration of the pain

**GOAL: Improvement of function to baseline as opposed to complete resolution of pain**

# Options

## Non-Pharmacologic Treatment

- Ice, heat, positioning, bracing, wrapping, splints, stretching
- Massage therapy, tactile stimulation, acupuncture/acupressure, chiropractic adjustment, osteopathic neuromusculoskeletal medicine
- Biofeedback
- Directed exercise such as physical therapy

## Non-Opioid Pharmacologic Treatment

| Role in Therapy | Somatic (Sharp or Stabbing) | Visceral (Ache or Pressure) | Neuropathic (Burning or Tingling) |
|---|---|---|---|
| First Line | Acetaminophen, NSAIDs, Corticosteroids | | Gabapentin/pregabalin/TCAs/SNRIs |
| Alternatives | Gabapentin/pregabalin, skeletal muscle relaxants, SSRIs/SNRIs/TCAs | SNRIs/TCAs, dicyclomine | Anti-epileptics, baclofen, bupropion, low-concentration capsaicin, SSRIs, topical lidocaine |

## Opioid Pharmacologic Treatment

### For All Opioids:

- **Complete risk screening** (e.g. age, pregnancy, high-risk psychosocial environment, personal/family history of substance use disorder).
- **Provide the patient with the least potent opioid** to effectively manage pain (e.g. APAP/codeine instead of oxycodone). **Refer to Morphine Equivalence Table.**
- **Prescribe the minimum quantity needed with no refills.**
- **Consider checking OARRS** for all patients who will receive an opioid prescription. (OARRS report is required for most prescriptions of 7 days or more.)
- **Avoid prescribing long-acting opioids** for acute pain (e.g. methadone, oxycodone).
- **Use caution when prescribing opioids** with patients on benzodiazepines and sedative-hypnotics or patients known to use alcohol.
- **Discuss how to safely and effectively wean** patient off opioid medication.
- **Remind that it is a unsafe and unlawful** to give away or sell their opioids.
- **Discuss proper storage and disposal of opioid medications.**
- **Coordinate care and communication** of complex patients with other clinicians.

### Morphine Equivalence Table

| Opioid Naive: Morphine Equivalence* | Notable NSAIDS |
|---|---|
| Most Potent | |
| Buprenorphine sublinguam 42:1 | |
| Hydromorphone PO 4:1 | |
| Oxymorphone 3:1 | |
| Hydrocodone 1:1 | |
| **Morphine 1:1** | |
| | Meloxicam 0.67:1 |
| | Diclofenac 0.2:1 |
| Codeine 0.15:1 | |
| Tramadol 0.1:1 | Celecoxib 0.1:1 |
| Least Potent | |

*Source: CDC, 5/2014

## 14 Days (Key Checkpoint)

Reassess patient within an appropriate time NOT exceeding 14 days

**If pain is unresolved, reassess:**

- Pain, consider standardized tool (e.g. Oswestry Disability Index for back pain)
- Treatment method
- Context and reason for continued pain
- Additional treatment options, including consultation

## Six Weeks (Key Checkpoint)

- If pain is unresolved:
- Repeat the prior step
- Refer to Chronic Pain Guideline

July 2015

# Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

## When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

## If RENEWING without patient visit

- ☐ Check that return visit is scheduled ≤3 months from last visit.

## When REASSESSING at return visit

***Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.***

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

### EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

### NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

### EVALUATING RISK OF HARM OR MISUSE

**Known risk factors** include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiet
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

**Urine drug testing**: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

**Prescription drug monitoring program (PDMP)**: Check for opioids or benzodiazepines from other sources.

### ASSESSING PAIN & FUNCTION USING PEG SCA

**PEG score** = average 3 individual question scores (30% improvement from baseline is clinically meaningf

**Q1:** *What number from 0–10 best describes your **pain** in the past week?*

0="no pain", 10="worst you can imagine"

**Q2:** *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*

0="not at all", 10="complete interference"

**Q3:** *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*

0="not at all", 10="complete interference"

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CS27380

TO LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline

# PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs)

## Checking the PDMP: An Important Step to Improving Opioid Prescribing Practices

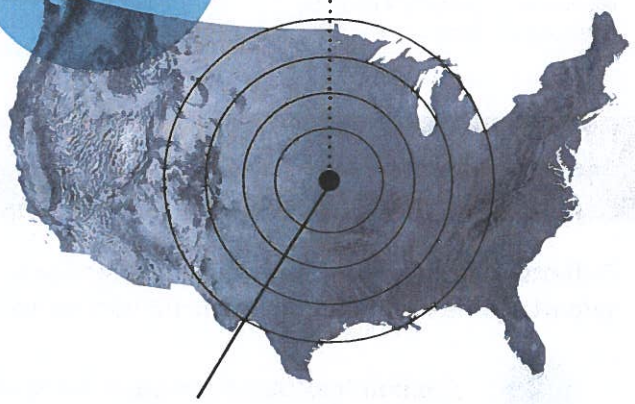
### WHAT IS A PDMP?

A PDMP is a statewide electronic database that tracks all controlled substance prescriptions. Authorized users can access prescription data such as medications dispensed and doses.

PDMPs improve patient safety by allowing clinicians to:

- Identify patients who are obtaining opioids from multiple providers.
- Calculate the total amount of opioids prescribed per day (in MME/day).
- Identify patients who are being prescribed other substances that may increase risk of opioids—such as benzodiazepines.

**249M** prescriptions for opioids were written by healthcare providers in 2013



**enough prescriptions for every American adult to have a bottle of pills**

**Improving the way opioids are prescribed will ensure patients have access to safer, more effective chronic pain treatment while reducing opioid misuse, abuse, and overdose. Checking your state's PDMP is an important step in safer prescribing of these drugs.**

### WHEN SHOULD I CHECK THE PDMP?

**State requirements vary, but CDC recommends checking at least once every 3 months and consider checking prior to every opioid prescription.**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LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

## WHAT SHOULD I CONSIDER WHEN PRESCRIBING OPIOIDS?

**High Dosage**

Talk to your patient about the risks for respiratory depression and overdose. Consider offering to taper opioids as well as prescribing naloxone for patients taking 50 MME/day or more.

**Multiple Providers**

Counsel your patient and coordinate care with their other prescribers to improve safety and discuss the need to obtain opioids from a single provider. Check the PDMP regularly and consider tapering or discontinuation of opioids if pattern continues.

**Drug Interactions**

Whenever possible, avoid prescribing opioids and benzodiazepines concurrently. Communicate with other prescribers to prioritize patient goals and weigh risks of concurrent opioid and benzodiazepine use.

## WHAT SHOULD I DO IF I FIND INFORMATION ABOUT A PATIENT IN THE PDMP THAT CONCERNS ME?

**Patients should not be dismissed from care based on PDMP information. Use the opportunity to provide potentially life-saving information and interventions.**

1. **Confirm that the information in the PDMP is correct.**
   Check for potential data entry errors, use of a nickname or maiden name, or possible identity theft to obtain prescriptions.

2. **Assess for possible misuse or abuse.**
   Offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients who meet criteria for opioid use disorder. If you suspect diversion, urine drug testing can assist in determining whether opioids can be discontinued without causing withdrawal.

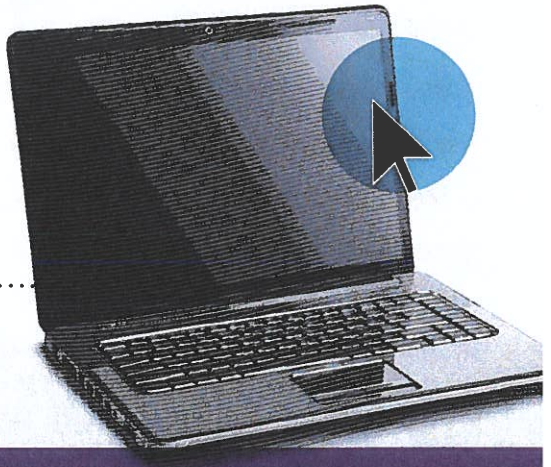
3. **Discuss any areas of concern with your patient and emphasize your interest in their safety.**

## HOW CAN I REGISTER AND USE THE PDMP IN MY STATE?

**Processes for registering and using PDMPs vary from state to state.**

**For information on your state's requirements, check The National Alliance for Model State Drug Laws online:**

**www.namsdl.org/prescription-monitoring-programs.cfm**



**LEARN MORE** | www.cdc.gov/drugoverdose/prescribing/guideline.html

ASAM American Society of Addiction Medicine

**Public Policy Statement on Prescription Drug Monitoring Programs (PDMPs)**

**Background**

Prescription Drug Monitoring Programs (PDMPs) are statewide electronic databases that collect designated data from pharmacies and medical offices that dispense controlled substances in the state. PDMPs are maintained at the state level and housed in various statewide regulatory, administrative, or law enforcement agencies. The overseeing agency provides access to the data to individuals who are authorized under state law to receive the information for purposes of their profession, mainly prescribers and dispensers.

PDMPs can be a useful tool to support safer prescribing and dispensing practices for scheduled medications. An American Medical Association survey found that 87% of responding physicians supported PDMPs because they help prescribers become more informed about a patient's prescription history. [1] PDMPs may also be a helpful tool to identify patients who merit an assessment for a substance use disorder (SUD).

The concept of a PDMP was originally developed by the Department of Justice to assist in prosecutions of criminal violations of the Controlled Substances Act. Over time, they became recognized as a useful decision support tool for prescribers when considering whether to prescribe a controlled substance or a medication that could have harmful drug-drug interactions with a controlled substance prescribed or dispensed by another party. Many newer state PDMPs allow access only to healthcare professionals and block access to the data by criminal investigators and prosecutors in the absence of a court order; others allow both healthcare professionals and law enforcement personnel to query a PDMP database.

It is important to note that each state PDMP is set up differently, in terms of which classes of medications are included, who has access to the data, timeliness and accuracy of the data, automatic reporting functions, and use requirements. Best practices for PDMP design and use include enacting and implementing interstate data sharing among PDMPs, integrating PDMP data with health information exchanges and electronic health records, mandating enrollment and utilization, improving data timeliness, allowing delegate access, and conducting user education.[2] An 'ideal' PDMP would also include peer to peer messaging (in compliance with HIPAA and 42 CFR Part 2) and provider peer review. One study suggests that more robust PDMP programs are associated with greater reductions in prescription opioid overdose.[3]

A notable gap in PDMP data is the absence of information about methadone or buprenorphine dispensed by opioid treatment programs (OTPs), as reporting such information would violate the federal confidentiality law that protects addiction treatment records (42 CFR Part 2). In a 2011 guidance letter, SAMHSA encouraged OTP staff to use PDMPs "as an additional resource to maximize safety of patient care" but explained that OTPs must comply with 42 CFR Part 2 and therefore, "disclosures of patient-identifying information by such programs to State PDMPs are not permitted unless an exception applies consistent with the federal confidentiality regulations."[4] However, thinking about the continued utility and desirability of the heightened privacy protections offered by 42 CFR Part 2 is evolving, and there have been several legislative and administrative efforts to modernize the law since the 2011 letter was issued. Many advocates believe the confidentiality law continues to be a necessary extra protection for patients seeking and receiving treatment for addiction, while others argue that segregating addiction treatment records contributes to stigma and denies patients the clinical benefits of PDMPs. While logistical barriers to reporting methadone and buprenorphine dispensed daily will remain, it is possible that the confidentiality law's legal barrier to reporting may be soon removed. It is within this evolving policy environment that ASAM offers the recommendations below.

**Recommendations:**

The American Society of Addiction Medicine (ASAM) makes the following recommendations regarding Prescription Drug Monitoring Programs.

1. Prescribers and dispensers should be required to enroll in and query the state's PDMP, either directly or by delegating access to office staff, when initiating a prescription for any controlled substance and at least every 3 months (quarterly) thereafter as treatment continues, consistent with the Centers for Disease Control and Prevention prescribing guidelines.
    a. Mandates should be implemented in conjunction with education about how to engage patients whose PDMP report suggests potential substance misuse and the risks of abruptly discontinuing chronic, prescribed opioid or benzodiazepine therapy.
    b. States should consider educational rather than punitive approaches to support prescribers and dispensers who do not enroll in or regularly query the PDMP as mandated.
2. States should ensure that PDMPs are functional, efficient, timely, user-friendly, and integrated into clinical work-flow by integrating them as much as possible with electronic health records and pharmacy dispensation systems.
3. State PDMP data should be accessible only for clinical treatment and/or evaluation (including consultations by clinicians who are not treating the patient) and for public health purposes by authorized clinicians and researchers, including for ongoing public health analysis that can critically evaluate the impact of any interventions on prescribing practices. On a case-by-case basis, law enforcement officials can be allowed access to PDMP data through subpoena and within a tightly regulated process.

4. The Department of Veterans Affairs (VA), the Indian Health Services (IHS), and similar federal healthcare agencies should report and transmit data to state PDMPs.
5. States should expand the medications reportable to the PDMP to include methadone and buprenorphine from OTPs, and cannabis obtained through a prescriber recommendation.
6. PDMPs that report total opioid morphine milligram equivalents (MME) should not include buprenorphine or methadone used to treat addiction involving opioid use in the calculation of MME; instead these should be reported separately. Without clinical context, a patient's total opioid dosage as measured by MME can be misleading[a] and lead to abrupt and inappropriate cessation of medically necessary treatment.

*Adopted by the ASAM Board of Directors April 11, 2018*



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[a] See ASAM Public Policy Statement on Morphine Equivalent Units/Morphine Milligram Equivalents. Available at: https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2016/10/11/public-policy-statement-on-morphine-equivalent-units-morphine-milligram-equivalents

[1] Survey: Physicians support PDMPs, face limits with non-opioid therapy [press release]. Chicago, IL: AMA News Room; February 18, 2016. https://www.ama-assn.org/content/national-survey-finds-physicians-support-pdmps-encounter-barriers-providing-non-opioid

[2] Clark T, Eadie J, Kreiner P, and Strickler G. Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices. September 20, 2012. Available at: http://www.pewtrusts.org/~/media/assets/0001/pdmp_update_1312013.pdf

[3] Pardo B. Do more robust prescription drug monitoring programs reduce prescription opioid overdose? Addiction. 2017 Oct ; 112(10):1773-1783.

[4] Clark HW. Dear Colleague letter. September 27, 2011. Available at: http://atforum.com/documents/dearColl-pmp2011.pdf

## Drug and Alcohol Policy

### Purpose

In compliance with the Drug-Free Workplace Act of 1988, [Company Name] has a longstanding commitment to provide a safe, quality-oriented and productive work environment. Alcohol and drug abuse poses a threat to the health and safety of [Company Name] employees and to the security of the company's equipment and facilities. For these reasons, [Company Name] is committed to the elimination of drug and alcohol use and abuse in the workplace.

### Scope

This policy applies to all employees and all applicants for employment of [Company Name]. The human resource (HR) department is responsible for policy administration.

### Employee Assistance

[Company Name] will assist and support employees who voluntarily seek help for drug or alcohol problems before becoming subject to discipline or termination under this or other [Company Name] policies. Such employees will be allowed to use accrued paid time off, placed on leaves of absence, referred to treatment providers and otherwise accommodated as required by law. Employees may be required to document that they are successfully following prescribed treatment and to take and pass follow-up tests if they hold jobs that are safety-sensitive or require driving, or if they have violated this policy previously. Once a drug test has been initiated under this policy, unless otherwise required by the Family and Medical Leave Act or the Americans with Disabilities Act, the employee will have forfeited the opportunity to be granted a leave of absence for treatment, and will face possible discipline, up to and including discharge.

Employees should report to work fit for duty and free of any adverse effects of illegal drugs or alcohol. This policy does not prohibit employees from the lawful use and possession of prescribed medications. Employees must, however, consult with their doctors about the medications' effect on their fitness for duty and ability to work safely, and they must promptly disclose any work restrictions to their supervisor.

### Work Rules

1. Whenever employees are working, are operating any [Company Name] vehicle, are present on [Company Name] premises or are conducting company-related work offsite, they are prohibited from:
    a. Using, possessing, buying, selling, manufacturing or dispensing an illegal drug (to include possession of drug paraphernalia).
    b. Being under the influence of alcohol or an illegal drug as defined in this policy.
    c. Possessing or consuming alcohol.
2. The presence of any detectable amount of any illegal drug, illegal controlled substance or alcohol in an employee's body system, while performing company business or while in a company facility, is prohibited.

3. [Company Name] will also not allow employees to perform their duties while taking prescribed drugs that are adversely affecting their ability to safely and effectively perform their job duties. Employees taking a prescribed medication must carry it in a container labeled by a licensed pharmacist or be prepared to produce the container if asked.
4. Any illegal drugs or drug paraphernalia will be turned over to an appropriate law enforcement agency and may result in criminal prosecution.

**Required Testing**

***Pre-employment***

Applicants being considered for hire must pass a drug test before beginning work or receiving an offer of employment. Refusal to submit to testing will result in disqualification of further employment consideration.

***Reasonable suspicion***

Employees are subject to testing based on (but not limited to) observations by at least two members of management of apparent workplace use, possession or impairment. HR, the plant manager or the director of operations should be consulted before sending an employee for testing. Management must use the Reasonable Suspicion Observation Checklist to document specific observations and behaviors that create a reasonable suspicion that an employee is under the influence of illegal drugs or alcohol. Examples include:

- Odors (smell of alcohol, body odor or urine).
- Movements (unsteady, fidgety, dizzy).
- Eyes (dilated, constricted or watery eyes, or involuntary eye movements).
- Face (flushed, sweating, confused or blank look).
- Speech (slurred, slow, distracted mid-thought, inability to verbalize thoughts).
- Emotions (argumentative, agitated, irritable, drowsy).
- Actions (yawning, twitching).
- Inactions (sleeping, unconscious, no reaction to questions).

When reasonable suspicion testing is warranted, both management and HR will meet with the employee to explain the observations and the requirement to undergo a drug and/or alcohol test within two hours. Refusal by an employee will be treated as a positive drug test result and will result in immediate termination of employment

*Under no circumstances will the employee be allowed to drive himself or herself to the testing facility. A member of management must transport the employee or arrange for a cab and arrange for the employee to be transported home.*

***Post-accident***

Employees are subject to testing when they cause or contribute to accidents that seriously damage a [Company Name] vehicle, machinery, equipment or property or that result in an injury to themselves or another employee requiring offsite medical attention. A circumstance that constitutes probable belief will be presumed to arise in any instance involving a work-related accident or injury in which an employee who was operating a motorized vehicle (including a [Company Name] forklift, pickup truck, overhead crane or aerial/man-lift) is found to be

responsible for causing the accident. In any of these instances, the investigation and subsequent testing must take place within two hours following the accident, if not sooner. Refusal by an employee will be treated as a positive drug test result and will result in immediate termination of employment.

*Under no circumstances will the employee be allowed to drive himself or herself to the testing facility. A member of management must transport the employee or arrange for a cab and arrange for the employee to be transported home.*

**Collection and Testing Procedures**

Employees subject to alcohol testing will be transported to a [Company Name]-designated facility and directed to provide breath specimens. Breath specimens will be tested by trained technicians using federally approved breath alcohol testing devices capable of producing printed results that identify the employee. If an employee's breath alcohol concentration is .04 or more, a second breath specimen will be tested approximately 20 minutes later. The results of the second test will be determinative. Alcohol tests may, however, be a breath, blood or saliva test, at the company's discretion. For purposes of this policy, test results generated by law enforcement or medical providers may be considered by the company as work rule violations.

Applicants and employees subject to drug testing will be transported to a [Company Name]-designated testing facility and directed to provide urine specimens. Applicants and employees may provide specimens in private unless they appear to be submitting altered, adulterated or substitute specimens. Collected specimens will be sent to a federally certified laboratory and tested for evidence of marijuana, cocaine, opiates, amphetamines, PCP, benzodiazepines, methadone, methaqualone and propoxphane use. (Where indicated, specimens may be tested for other illegal drugs.) The laboratory will screen all specimens and confirm all positive screens. There must be a chain of custody from the time specimens are collected through testing and storage.

The laboratory will transmit all positive drug test results to a medical review officer (MRO) retained by [Company Name], who will offer individuals with positive results a reasonable opportunity to rebut or explain the results. Individuals with positive test results may also ask the MRO to have their split specimen sent to another federally certified laboratory to be tested at the applicant's or employee's own expense. Such requests must be made within 72 hours of notice of test results. If the second facility fails to find any evidence of drug use in the split specimen, the employee or applicant will be treated as passing the test. In no event should a positive test result be communicated to [Company Name] until such time that the MRO has confirmed the test to be positive.

**Consequences**

Applicants who refuse to cooperate in a drug test or who test positive will not be hired and will not be allowed to reapply/retest in the future.

Employees who refuse to cooperate in required tests or who use, possess, buy, sell, manufacture or dispense an illegal drug in violation of this policy will be terminated. If the employee refuses to be tested, yet the company believes he or she is impaired, under no circumstances will the employee be allowed to drive himself or herself home.

Employees who test positive, or otherwise violate this policy, will be subject to discipline, up to and including termination. Depending on the circumstances, the employee's work history/record and any state law requirements, [Company Name] may offer an employee who violates this policy or tests positive the opportunity to return to work on a last-chance basis pursuant to mutually agreeable terms, which could include follow-up drug testing at times and frequencies determined by [Company Name] for a minimum of one year but not more than two years as well as a waiver of the right to contest any termination resulting from a subsequent positive test. If the employee either does not complete the rehabilitation program or tests positive after completing the rehabilitation program, the employee will be immediately discharged from employment.

Employees will be paid for time spent in alcohol or drug testing and then suspended pending the results of the drug or alcohol test. After the results of the test are received, a date and time will be scheduled to discuss the results of the test; this meeting will include a member of management, a union representative (if requested), and HR. Should the results prove to be negative, the employee will receive back pay for the times/days of suspension.

**Confidentiality**

Information and records relating to positive test results, drug and alcohol dependencies, and legitimate medical explanations provided to the MRO will be kept confidential to the extent required by law and maintained in secure files separate from normal personnel files. Such records and information may be disclosed among managers and supervisors on a need-to-know basis and may also be disclosed when relevant to a grievance, charge, claim or other legal proceeding initiated by or on behalf of an employee or applicant.

**Inspections**

[Company Name] reserves the right to inspect all portions of its premises for drugs, alcohol or other contraband; affected employees may have union representation involved in this process. All employees, contract employees and visitors may be asked to cooperate in inspections of their persons, work areas and property that might conceal a drug, alcohol or other contraband. Employees who possess such contraband or refuse to cooperate in such inspections are subject to appropriate discipline, up to and including discharge.

**Crimes Involving Drugs**

[Company Name] prohibits all employees, including employees performing work under government contracts, from manufacturing, distributing, dispensing, possessing or using an illegal drug in or on company premises or while conducting company business. [Company Name] employees are also prohibited from misusing legally prescribed or over-the-counter (OTC) drugs. Law enforcement personnel may be notified, as appropriate, when criminal activity is suspected.

[Company Name] does not desire to intrude into the private lives of its employees but recognizes that employees' off-the-job involvement with drugs and alcohol may have an impact on the workplace. Therefore, [Company Name] reserves the right to take appropriate disciplinary action for drug use, sale or distribution while off company premises. All employees who are convicted of, plead guilty to or are sentenced for a crime involving an illegal drug are required to report the conviction, plea or sentence to HR within five days. Failure to comply will

result in automatic discharge. Cooperation in complying may result in suspension without pay to allow management to review the nature of the charges and the employee's past record with [Company Name].

**Definitions**

"Company premises" includes all buildings, offices, facilities, grounds, parking lots, lockers, places and vehicles owned, leased or managed by [Company Name] or any site on which the company is conducting business.

"Illegal drug" means a substance whose use or possession is controlled by federal law but that is not being used or possessed under the supervision of a licensed health care professional. (Controlled substances are listed in Schedules I-V of 21 C.F.R. Part 1308.)

"Refuse to cooperate" means to obstruct the collection or testing process; to submit an altered, adulterated or substitute sample; to fail to show up for a scheduled test; to refuse to complete the requested drug testing forms; or to fail to promptly provide specimen(s) for testing when directed to do so, without a valid medical basis for the failure. Employees who leave the scene of an accident without justifiable explanation prior to submission to drug and alcohol testing will also be considered to have refused to cooperate and will automatically be subject to discharge.

"Under the influence of alcohol" means an alcohol concentration equal to or greater than .04, or actions, appearance, speech or bodily odors that reasonably cause a supervisor to conclude that an employee is impaired because of alcohol use.

"Under the influence of drugs" means a confirmed positive test result for illegal drug use per this policy. In addition, it means the misuse of legal drugs (prescription and possibly OTC) when there is not a valid prescription from a physician for the lawful use of a drug in the course of medical treatment (containers must include the patient's name, the name of the substance, quantity/amount to be taken and the period of authorization).

**Enforcement**

The HR director is responsible for policy interpretation, administration and enforcement.

**Drug and Alcohol Policy Certificate of Receipt**

I hereby certify that I have received a copy of [Company Name's] Drug and Alcohol Policy.

_____ _____

Employee Signature Date

[PATIENT LETTER – CHRONIC PAIN MANAGEMENT]

Dear Patient:

Doctors, nurses, and pharmacists in Ohio are worried about the misuse of pain medicine. State officials are concerned too. We see too many deaths from the misuse of pain medicine.

Every time you fill your prescription for pain medicine, it goes into a registry. Anyone who writes a prescription for pain medicine must check that registry. We all are working together to make sure people get treated for pain safely.

That is why I will talk with you about a plan to treat your pain, including any pain medicines I prescribe for you.

Here are some things we will discuss:

- Your pain level, medicines and treatment.
- Your medical records.
- What happens when you take pain medicine for a long time
- The proper use of your medicines. We want to make sure you safely store them. We do not want anyone else taking your medicines.
- I may need to talk to your other doctors, nurses and dentists about the medicines you take.

I also want you to answer these questions with me:

1. Does your pain prevent you from normal activities?
2. What side effects might happen if you take pain medicine?
3. What signs of unusual behavior do we need to look for?

We may ask you to sign a patient agreement that includes things like:

- Participating in treatments that do not include some types of pain medicine.
- Telling the doctor's office about other medicines you are taking, and when another doctor gives you a prescription for a new medicine.
- Periodic drug screens
- One pharmacy for prescriptions
- One doctor to prescribe your pain medicine
- What happens if you do not follow this agreement

You may need to see a specialist. This would be a physician who treats the part of the body where you feel pain.

I am concerned about your safety. Call me if you ever think you are addicted to your medicine. You also can call the 1-877-275-6364 toll-free number. Your call is confidential. They will refer you to someone for help. You can call them from Monday through Friday between 8 a.m. and 5 p.m.

I look forward to helping you with your pain.

Sincerely,

[PATIENT LETTER – ACUTE PAIN TREATMENT]

Dear Patient:

Doctors, nurses, and pharmacists in Ohio are worried about the misuse of pain medicine. Ohio sees too many deaths from the misuse of prescription pain medicine. That is why I will talk with you about a plan to treat your pain safely.

We will start by talking about:

- Your pain level.
- Your medical history.
- Any history of drug abuse by you or family members.

We will work together to create a pain treatment plan for you. We will discuss things like:

- Ways to treat your pain without prescription pain medicine.
- Other pain medicines you can take.
- How to take prescription pain medicine safely if you need it.
- Limiting the amount of prescription pain medicine you receive to keep you safe.
- Being careful about what other medicine you take with prescription pain medicine.
- Touching base to see how you are doing.

We also will talk about:

- How to safely store your prescription pain medicine so other people cannot take it.
- How to safely throw away pain medicine that you do not use.
- Whether we should sign an agreement that says what you and your doctor will do in order to keep you safe when you are taking a prescription pain medicine.

I care about your safety. That is why I will talk with you about all of these things and work with you to treat your pain safely.

Sincerely,

**Patient Agreement Form**

**Patient Name:**

**Medical Record Number:** **Addressograph Stamp:**

## AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

The use of _____(print names of medication(s)) may cause addiction and is only one part of the treatment for: _____ (print name of condition—e.g., pain, anxiety, etc.).

The goals of this medicine are:

☐to improve my ability to work and function at home.

☐to help my _____ (print name of condition—e.g., pain, anxiety, etc.) as much as possible without causing dangerous side effects.

I have been told that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
2. I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

**I agree to the following:**

- I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.
- I will not increase my medicine until I speak with my doctor or nurse.
- My medicine may not be replaced if it is lost, stole, or used up sooner than prescribed.
- I will keep all appointments set up by my doctor (e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management)
- I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
- I agree to give a blood or urine sample, if asked, to test for drug use.

Refills

Refills will be made only during regular office hours—Monday through Friday. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. **No exceptions will be made.** I will not come to primary care for my refill until I am called by the nurse.

I must keep track of my medications. No early or emergency refills may be made.

Pharmacy

I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.

The name of my pharmacy is_____.

Prescriptions from Other Doctors

**If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.), I must bring this medicine to primary care in the original bottle, even if there are no pills left.**

***Privacy***

While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

Termination of Agreement

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way.

I have talked about this agreement with my doctor and I understand the above rules.

Provider Responsibilities

As your doctor, I agree to perform regular checks to see how well the medicine is working.

I agree to provide primary care for you even if you are no longer getting controlled medicines from me.

_____ _____

Patient's Signature Date

_____

Resident Physician's Signature

_____

Attending Physician's Signature

☐This document has been discussed with and signed by the physician and patient. (A signed copy stamped with patient's card should be sent to the medical records department and a copy given to the patient.)

## Pain Treatment with Opioid Medications: 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 my 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 members 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 appointment 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 our 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://painmed.org./Workarea/Download Asset.aspx?id=3203

## Drug Testing for Opioids Policy

According to an evidence assessment by the American Society of Interventional Pain Physicians (ASIPP), approximately one-third of chronic pain patients do not use opioids as prescribed or may abuse them.[1] Moreover, studies report that a substantial proportion of chronic pain patients inaccurately report nonadherence to prescribed medications and use of illicit drugs.[2]

According to the National Pharmaceutical Council (NPC) and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) guideline regarding current understanding of assessment, management, and treatment of pain, the primary drugs used to treat pain may be categorized into three classes:[3]

• Nonopioid analgesics (nonopioids): acetaminophen and nonsteroidal antiinflammatory drugs (NSAIDs), including aspirin and other salicylic acid derivatives.

• Opioid analgesics (opioids): mu opioid agonists (i.e., morphine-like agonists) and agonist-antagonist opioids.

• Adjuvant analgesics or co-analgesics: a diverse group of drugs, with primary indications for conditions other than pain, with analgesic properties relevant to some conditions. Commonly used adjuvant analgesics include antiepileptic drugs (AEDs), tricyclic antidepressants (TCAs), and local anesthetics (LAs).

The NPC notes that, "variations of this classification system exist, and terminology in the field is also evolving."

**Monitoring Drug Use**

Various strategies are available to monitor patients in pain management and substance abuse treatment. Multicomponent interventions are often used which may include patient contracts, risk assessment screening instruments and tracking of aberrant behaviors. One strategy for monitoring patients is testing of biological specimens for the presence or absence of drugs. Currently, urine is the most commonly used biological substance. Advantages of urine sampling are that it is readily available, and there are standardized techniques for detecting drugs in urine. Other biological specimens (e.g., blood, oral fluids, hair and sweat) can also be tested and may gain popularity over time as techniques for collecting and analyzing these specimens become more standardized.

**Urine Drug Testing**

There are various approaches to incorporating urine drug screening into pain management and substance abuse treatment settings. Most commonly, patients undergo urine drug screening before beginning treatment to verify current drug use. Some clinicians believe that urine drug screening should be routinely used to establish baseline information about substance use, but the optimal frequency and interval of testing remains uncertain. A universal approach to screening may uncover more inappropriate use, and may reduce patients' sense that testing is being performed due to a lack of trust. However, routine universal screening may place an unnecessary burden on the healthcare system and on the doctor-patient relationship. An alternative approach is selective testing of patients who are judged to be at increased risk for drug misuse.

Full informed consent is a requirement before urine drug testing. Patients should be informed of the specific drug testing protocol before treatment and should provide written agreement with the plan for monitoring. As stated in a joint U.S. Veterans Affairs/Department of Defense guideline, patients' refusal to consent to urine testing should be considered as one factor in the overall assessment of patients' ability to adhere to treatment.[4]

There are two primary categories of urine drug testing:

I. Presumptive Immunoassay (Qualitative) Testing

These tests can be performed either in a laboratory or at point-of-service with Certification of Waiver or a Medical Test Site Accredited License. Presumptive immunoassay tests are based on the principle of competitive binding and use antibodies to detect a particular drug or drug metabolite in a urine sample. With competitive binding, a fixed amount of a labeled drug is added to the urine sample, and the drug or metabolite in the sample competes with the labeled drug for binding sites on the antibody. The amount of labeled antigen that binds with the antibody is inversely proportional to the amount of the drug or metabolite in the sample.

Presumptive immunoassay tests vary in the type of compounds they can detect. Some detect specific drugs and may fail to recognize similarly structured drugs within the same class. Other immunoassays identify only classes of drugs and thus results cannot be used to determine which drug a patient is taking. For example, a positive result to an opiate immunoassay can be due to morphine or hydromorphone. The degree of crossreactivity, i.e., an antibody's reactivity with a compound other than the target of the test, varies widely among immunoassays.

Presumptive immunoassay findings are generally reported qualitatively as either positive (drug level above a prespecified threshold) or negative (drug level below a prespecified threshold). Raising or lowering the threshold thus changes the proportion of positive tests. A negative test is interpreted as a level below the threshold and does not necessarily mean that the drug or metabolite is absent.

Immunoassays generally have a rapid turnaround time, within minutes for onsite tests and 1 to 4 hours for laboratory-based tests.[5]

II. Definitive Confirmatory (Quantitative) Testing to Identify a Specific Drug

Confirmatory tests are performed in a laboratory or by a provider with Certificate of Registration, Compliance of Accreditation or Medical Test Site Categorized License or Accredited License. Gas chromatography/mass spectrometry (GC/MS) is considered to be the criterion standard for confirmatory testing. This technique involves using GC to separate the analytes in a specimen and MS to identify the specific molecular structures of the drug and its metabolites. The tests are able to quantify the amount of drug or metabolite present in the urine sample. Quantitative tests can be used to confirm the presence of a specific drug identified by a screening test and can identify drugs that cannot be isolated by currently available immunoassays. Results are reported as the specific levels of substances detected in the urine. GC/MS generally requires specification of the drug or drugs to be identified. Alternatively, "broad spectrum screens" can be conducted. There is a several day turnaround time for GC/MS testing.[6]

### Urine Drug Test Accuracy

An issue with both types of urine drug testing is the possibility of sample tampering to mask the presence of illegal drugs. A variety of products and techniques are available to patients, and can be as simple as drinking a large amount of water to dilute the sample. There are also commercial dilution and cleaning products, additives and urine substitutes. Some of these techniques can be detected by visual inspection of the sample (e.g., color, or by onsite testing of sample characteristics including urine temperature, creatinine concentration, and specific gravity).

In addition, correct interpretation of urine drug testing results is very important. Knowledge of drug metabolites is essential for accurate interpretation. Accurate interpretation of test results also requires knowledge of the drug manufacturing process. For example, due to manufacturing impurities, a small amount of hydrocodone may be present in urine samples from patients prescribed oxycodone. Thus, it would be acceptable to have this degree of hydrocodone if high amounts of oxycodone were also present.

### Urine Drug Testing Strategy

Existing protocols vary for use of qualitative versus quantitative tests. Some of these involve conducting routine confirmation of positive qualitative tests with quantitative testing. Others use selective confirmation of positive qualitative tests, such as when an unexpected immunoassay result is not adequately explained by the patient. There is also a mixed approach, with routine conformation of qualitative tests only for drugs with poor-performing presumptive immunoassays.

## Practice Guideline Summary

#### CENTERS FOR DISEASE CONTROL AND PREVENTION

In 2016, Centers for Disease Control and Prevention (CDC) guidelines on opioids for chronic pain was published.[14] The guidelines included the following recommendation on UDT: "When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs."

#### AMERICAN PAIN SOCIETY AND AMERICAN ACADEMY OF PAIN MEDICINE

In 2009, the American Pain Society (APS) and American Academy of Pain and Medicine (AAPM) issued joint clinical practice guidelines on the use of opioid therapy in chronic noncancer pain.[19] The clinical guidelines were based upon a high quality systematic review of the current evidence which included a comprehensive literature search and transparent appraisal of the quality of evidence. The APS/AAPM guideline indicated the following:

> "Patients with chronic pain may underreport or conceal illicit drug use. Regular or periodic urine drug screening has been proposed as a method for identifying patients using illicit drugs. Most urine drug screening tests utilize immunoassays, but cross reactivity between various drugs and chemicals can cause false positive results. Urine tests based on gas chromatography-mass spectrometry assays are considered the most specific test for identifying individual drugs and metabolites and are often used to confirm positive results on immunoassays."

The APS/AAPM found the evidence regarding the diagnostic accuracy or urine drug screening to be limited to a single study with methodological shortcomings.

**AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE**

The latest guidelines from the American College of Occupational and Environmental Medicine (ACOEM) on the use of opioids for the treatment of acute, subacute, chronic, and postoperative pain, were published in 2014.[20] An expert panel was convened to evaluate the current evidence, and develop recommendations. For urine drug testing, the panel recommended both presumptive and definitive testing at baseline and at random, "for patients prescribed opioids for the treatment of subacute [1-3 months] or chronic pain [> 3 months] to evaluate presence or absence of the drug, its metabolites and other substance(s) use. In certain situations, other screenings (eg, hair particularly for information regarding remote use or blood) (for acute toxicity) may be appropriate." The recommendation strength was graded: C (on a scale of A-C, where A is strongly recommended, B is moderately recommended, and C is recommended); and the confidence in the recommendation was labeled: High.

Urine drug screening was not recommended for acute pain (up to 4 weeks) or for postoperative pain (up to 4 weeks).

As a companion to the guidelines, ACOEM developed a combined Opioid Consent Form and Opioid Treatment Agreement.[21] The form provides explanations of the potential benefits and harms to be expected from opioid treatment, and asks the patient to agree to numerous terms of opioid use, which include submitting to unscheduled urine, blood, saliva, or hair drug testing at the prescriber's request and seeing an addiction specialist if requested.

Screening was recommended for all patients at baseline, and then randomly at least twice and up to four times a year, and at termination. Screening should also be performed if the provider suspects abuse of prescribed medication.

**VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE**

In 2010, the Veterans Affairs (VA) and Department of Defense (DoD) issued clinical practice guidelines for managing opioid therapy for chronic pain treatment.[4] The recommendations on assessing adherence to prescribed opioids includes obtaining a urine drug test before initiating opioid therapy and randomly at follow-up to confirm appropriate use. Other strategies recommended include clinical assessment and screening aids such as random pill counts, adherence checklists and standardized instruments such as the Screener and Opioid Assessment for Patients with Pain (SOAPP).

The guideline included the following specific recommendations regarding urine drug testing:

1. "Inform patients that drug testing is a routine procedure for all patients starting or on opioid therapy (OT), and is an important tool for monitoring the safety of their treatment.

2. With patient consent, obtain a urinary drug test (UDT) in all patients prior to initiation of OT.

3. With patient consent monitor all patients on OT with periodic random UDTs to confirm adherence to the treatment plan. Increase the frequency of UDTs based on risk level for aberrant drug-related behaviors and following each dose increase.

4. Take into consideration a patient's refusal to take a UDT as part of the ongoing assessment of the patient's ability to adhere to the treatment plan and the level of risk for adverse outcomes.

5. When interpreting UDT results take into account other clinical information (e.g., past substance use disorder [SUD], other risk factors, aberrant drug-related behaviors, and other conditions indicating risk.)

6. Understanding of lab methods for drug testing and reporting are necessary to interpret UDT results (i.e., screen versus confirmatory test, substances tested, cut-off levels for tests). Maintain a close working relationship with the clinical laboratory to answer any questions about the UDT or for confirming the results."

Specific recommendations regarding confirmatory urine drug testing were not included in the VA/DoD guidelines.

**AMERICAN SOCIETY OF ADDICTION MEDICINE**

The American Society of Addiction Medicine (ASAM) has published several documents on drug testing: a public policy statement (2010),[22] a white paper (2013), which provided background on the science and current practices of drug testing,[23] and guidelines (2017) on the effective use of drug testing.[24] ASAM's public policy statement asserts that: "Urine drug testing is a key diagnostic and therapeutic tool that is useful for patient care and in monitoring of the ongoing status of a person who has been treated for addiction. As such, it is a part of medical care, and should not face undue restrictions."[22] ASAM recommended drug testing where medically appropriate in clinical diagnostic settings and clinical treatment settings. The term "drug testing" in this document was a broad term that included urine or other body fluids or tissues.

The ASAM White Paper concluded that "The most important challenge in drug testing today is not the identification of every drug that we are technologically capable of detecting, but to do medically necessary and accurate testing for those drugs that are most likely to impact clinical outcomes."[23] The paper acknowledged that more specific guidance on drug testing was needed, which led to the development of the 2017 guidelines, described below.

The 2017 ASAM guidance on appropriate drug testing in clinical addiction medicine advises health care providers that before choosing the type of drug test, they should first identify the questions they are seeking to answer and be aware of benefits and limitations of the various drug tests.

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## What is Opioid Use Misuse and What is Opioid Use Disorder?

There are almost **2.6 Million** Americans with a substance abuse disorder involving prescription opioid painkillers or heroin

## So what is an Opioid?

Opioids are drugs that reduce the intensity of pain signals. The word "opioid" comes from opium, a drug made from the poppy plant. Opiates cover a huge variety of drugs, ranging from legal drugs such as fentanyl, codeine, and morphine to illegal drugs such as heroin and opium. They slow down some body functions such as heartbeat and breathing, and cause a person to feel increased pleasure. They also can make a person drowsy, nauseous, confused and constipated.

## How does Opioid Misuse move to a Disorder?

Opioid use can create brain changes that lead to addiction. This can happen when a person takes heroin to get high or takes more of a painkiller than has been prescribed by a doctor. A person who is addicted develops an overpowering urge for the drug. This is called a *craving*. The person also experiences a loss of control, making it more difficult to refuse the drug, when use becomes harmful. Most people who are addicted to opioids cannot *taper off* (use less of the drug over time) without help. Addiction to opioids impacts the brain more severely than addiction to other substances. Habitual long-term use of opioids, including heroin and prescription painkillers, results in intense physical cravings for continued use of more opioids.

## What does Tolerance, Dependence and Withdrawal have to do with it?

Drugs of abuse overload the body with dopamine- in other words, they cause the reward system to send too many "feel-good" signals through. As time goes on, the body needs more of the drug to feel the same effects as before. This is known as *tolerance*. People can develop a *dependence* on opioids, which means they feel sick if there is no opioids in the body. This sickness, called *withdrawal*, can cause many unpleasant and painful symptoms.

## What is Addiction?

Addiction, is a disease. You are addicted to a drug when it seems that neither your body nor your mind can function without the drug. Addiction causes you to obsessively seek out the drug, even when the drug use causes behavior, health, or relationship problems. Opioid addiction is a chronic disease, like ADHD, diabetes or asthma. It may last for life. While it may not be cured, it can be managed.

When someone is diagnosed with a chronic disease such as diabetes or heart disease, a doctor may prescribe medication such as insulin or statins and often recommend lifestyle changes such as more exercise and a healthier diet. Treating opioid addiction also can involve a combination of medication, therapy and lifestyle changes.

The good news is that there are a variety of effective treatments for opioid addiction that will allow a person to return to a life that is healthy and addiction-free. This process is called *recovery*.

## How can Opioid Use Misuse be Treated?

Most people are unable to stop taking drugs "cold turkey." Substance abuse treatment providers and doctors can help people stop using the drug they are addicted to, control their cravings and get them through withdrawal. While many people would like to recover from long-term opioid addiction, without the help of medication, they often find they relapse-go back to using drugs.

Treatment varies and may include: individual and group counseling, inpatient and residential treatment, intensive outpatient treatment, partial hospital programs, case or care management, medication, recovery support services, 12-step fellowship, peer supports

## How can you help?

Waiting for someone to ask for help, is a risky strategy. When you discover that someone you know has an opioid addiction, the first route to take with them might need to be more than just saying "Please quit." Before beginning the conversation, it can be helpful to explore all treatment options. Open communication is one of your best tools. And remember that opioid addiction is a disease, not a choice. You need to be direct, not apathetic. You can also remind them that you recognize the difference between the person and the opioid addiction, you support one and reject the other.

Formal treatment takes many forms and no one type of treatment is best for everyone. There are many roads to recovery.

Making a referral for treatment

Most individuals believe they can overcome their addiction by themselves. They often hold steadfast to the notion that they do not have a problem and if they admit they do, they believe that they can get help when the time is right. This unrealistic expectation often leads to the addict continuing to use drugs, alcohol, or another disorder, often breaking the promises to themselves and others that they will get clean or stop. They spiral out of control and go down a road that that often leads to low self-esteem, depression and further abuse.

Referral to treatment is a critical component of the treatment process. It involves establishing a clear method of follow-up with patients that have been identified as having a possible dependency on a substance or in need of specialized treatment. What are some key considerations? Referring clients to treatment usually involves:

- Assisting a patient with accessing specialized treatment
- Selecting an appropriate treatment facility
- Helping navigate barriers to treatment

The manner in which a referral to treatment is provided can have a tremendous impact on whether the client will actually follow through and seek services with the referred provider, or not. So, how can you streamline this process?

The first step for any referral professional should be to call the addiction treatment program and begin to ask questions.

It is okay to admit that you are not the expert when it comes to Substance Use Disorders or navigating the admissions process. It can be really complicated at times. Allow the Admissions Coordinator, or their designated representative, to explain the process to you, including:

- Admission criteria
- Insurances the program accepts
- An example of the patient's daily schedule
- Treatment planning
- Discharge/aftercare planning

**Should referrals be local, or can they be out-of-state?**

The determining factor is usually whether or not a program is contracted with the individual's insurance carrier. Additionally, some individuals choose to self-pay for treatment, which eliminates the need to utilize their insurance (if they choose).

**What kinds of release papers are required in order to set up a referral relationship with an addiction treatment center?**

A release of information for that provider is usually the first form, this can be obtained from the treatment center. This will allow communication to continue with the referring provider and provide them with updates about a person's progress, their treatment plan, and coordinate their discharge.

**How often should the treatment center send the referring source client updates?**

It is important for referring providers to be clear about their expectations for the program providing the treatment. Generally, with proper releases, treatment centers will send as little or as much information as they would like, and at whatever interval they would like.

**What are some of the Best Practices in information sharing between the treatment center and "home" referral source?**

It is important that all parties involved in a referral to treatment for Substance Use Disorders acknowledge the importance of each other's contribution to the care of the particular individual, and in doing so, agree that the frequency and content of communication should match the clinical need.

Medication changes, mental status changes, risk of self harm, harm to others, or a decrease in a person's level of cooperation in a program are examples of common situations that would initiate communication between providers. The more information a referring provider gives about a client, increases the likelihood of successful outcomes.

**Continuity of Care is a big issue when dealing with referrals. What are some examples of common mistakes that both treatment centers and a referring provider might make? How can these be avoided?**

One mistake made by referring providers is allowing clients to believe that a quick detox or a short stint in an inpatient program will take care of their Substance Use Disorder.

Addiction is not like the flu. It does not take over your life, run its course, then go away and you suddenly feel all better. Addiction is a chronic disease that is treatable, and should be part of a person's regular conversations with their Primary Care Physician and/or Mental Health Providers, to ensure that symptoms are recognized early and can be addressed.

Aftercare is vital to a person's successful recovery from Substance Use Disorder(s) and should be encouraged by providers whom they have frequent contact. For example, a discharge coordinator may set up Intensive Outpatient or Outpatient Treatment, mental health appointments, supportive housing, encourage 12-Step Involvement, and array of other services deemed appropriate to help in these early stages.

**How are patients included in the process of selecting treatment they'll be referred to? How often are their preferences different than those suggested by the treatment center?**

Any person seeking treatment, whether it is at an inpatient program or on an outpatient basis, should be very involved in the process.

For admission into any program, a person will have an initial assessment by a qualified Substance Abuse Professional to determine what level of care a person needs. Once this is done, there should be several options laid out for the person that should be discussed with whomever will be involved in the referral process, including family if the person wishes them to be. From this point, the individual should begin their research process and determine availability at each of the programs.

There are times that individual preferences may differ from the suggestions of the Substance Abuse Professional. Ultimately, the client has the choice to make, and it will either be aligned with what the professional assessment suggests, or they will try another way. Sometimes this works out, sometimes it

does not, and they end up having to reconvene and decide on another treatment option for the person. It's very important to not look at these instances as failures, but rather an opportunity for learning more about themselves, the disease of addiction, and other available options.

## Preparing Individuals for Treatment

After you've committed to going to an addiction treatment center, it's time to think about the steps you should take in order to be fully prepared for your stay in rehab.

It's common to feel stressed over putting things such as your job, bills or family obligations on hold while you're in rehab. However, it's important to understand that all of these things can be dealt with by taking time to prepare for treatment.

You have already made the difficult decision that it's time to get help. Now, it's just about taking the appropriate measures that will allow you to return to a positive space where you can successfully use the skills you learned in rehab.

**Steps to preparing for Treatment**

- Taking care of work and family obligations

You might be hesitant to mention your upcoming rehab stay to your employer, but anyone who appreciates you as an employee will want you to get better. They want the healthiest, happiest and best version of you, so the sooner you can let your employer know, the better.

According to the Family and Medical Leave Act, you are entitled to up to 12 weeks of medical leave, so your job will be protected during your stay in treatment.

If you're a caregiver to children, elderly parents or even your pets, now is the time to make sure your loved ones are being taken care of while you're away. Ask you family or friends to look after your children or pets, or look into options for temporary care. It will help put your mind at ease to know the people you love are in good hands while you're away.

- Tie up any Financial or Legal loose ends

If you have bills that need to be paid while you're out, make sure you sign up for automatic payments or speak to someone you trust about making sure your bills get paid. You definitely won't want to come back, ready to tackle life, and be saddled with financial stress.

If necessary, let the courts know- whether via your own correspondence or through your attorney- that you will be entering a Treatment facility so they are aware you may be out of touch. Even if you Treatment stay is verbally understood, it's always good to get a legal "OK" on paper.

- Make sure you have the essential- and only the essentials

It can be tempting to bring everything with you that reminds you of home, but taking only the things you really need will make sure you are adhering to your treatment center's set of allowable items.

By sticking to the essentials, you will also minimize any outside distractions that can compromise your sobriety. While in treatment, your focus should be mostly on yourself and getting the best treatment you can, so leave any "extras" behind- they'll be there for you when you get back.

"I would say go with anything you have and if not, go with nothing-but go! It can change life, it has for me! The clothes and stuff you can get later, but you probably won't have another opportunity to save your life" -Jacqueline V., recovering addict

**Supporting individuals in Treatment**

Because successful outcomes often depends on a person's staying in treatment long enough to reap the benefits, strategies for keeping people in treatment are critical. Whether a patient stays in treatment depends on factors associated with both the individual and the program. Individual factors related to engagement and retention typically include motivation to change drug-using behavior; degree of support from family and friends; and frequently, pressure from the criminal justice system, child protection services, employers, or family.

The appropriate duration for an individual depends on the type and degree of the patient's problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. Recovery from addiction is a long-term process and frequently requires multiple episodes of treatment. As with chronic illnesses, relapses to drug abuse can occur and should signal a need for treatment to be reinstated or adjusted.

Because some problems (such as serious medical or mental illness or criminal involvement) increase the likelihood of patients dropping out of treatment, intensive interventions may be required to retain them.

Family and friends can play critical roles in motivating individuals with Substance Use Disorder to enter and stay in treatment. Family therapy can also be important, especially for adolescents. Involvement of a family member or significant other in an individual's treatment program can strengthen and extend treatment benefits.

Continued support of their participation in their ongoing care, meetings and recovery support groups is essential. Be the support system they need, and show them you'll be there every step of the way.

Remember to take care of yourself, although you may see this as selfish, it's incredibly important that you're able to be there for others and make the best decisions possible. Make sure your own needs are met by getting enough sleep, exercising, and eating well. Don't be afraid to go to therapy to get help if you find yourself struggling due to your loved one's drug addiction.

Some things to not do:

- Don't Preach: Don't lecture, threaten, bribe, preach, or moralize
- Don't be a Martyr: Avoid emotional appeals that may only increase feelings of guilt and the compulsion to drink or use other drugs
- Don't Cover Up , lie, or make excuses for them and their behavior
- Don't Assume Their Responsibilities: Taking over their responsibilities protects them from the consequences of their behavior
- Don't Argue When Using: Arguing with a person when they are using alcohol or drugs is not helpful; at that point they can't have a rational conversation
- Don't Feel Guilty or responsible for their behavior, it's not your fault
- Don't Join Them: Don't try to keep up with them by drinking or using yourself