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Opioid Use Disorder: Information for Physicians



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Sommaire : Although opioids can be helpful for many patients, when misused, they can wreak havoc with patients lives. Fortunately, primary care providers can play a key role in preventing opioid disorder, as well as its identification. Because of the nature of opioid use disorder, simply telling patients to stop using is rarely successful. Rather, using strategies such as motivational enhancement strategies that validate the patient's underlying feelings are more likely to be successful. Like all human beings, when patients feel that they are being listened to and validated, they are more likely to accept support from their primary care provider. If necessary then, patients will then be willing to accept gentle encouragement to formal opioid treatment programs if necessary.

Case

- O. is a 29-yo female known to you for many years, who is single, and works as a pharmacy technician
- Past history
  - R intra-articular ankle fracture at age 13 which has left her with chronic pain.
  - Generalized anxiety disorder for which you treated her with psychotherapy and citalopram
- Over the last 3 years, her right ankle pain has been worsening.
- Many interventions have been tried
  - Conservative measures – physiotherapy, acetaminophen, topical NSAIDs, and a referral to Sports Medicine for injection.
  - Orthopedics performed a fusion of the joint but her pain worsened following the surgery.
  - Opioids immediately following the surgery, which have been continued as she reports of persistent and unbearable pain.
- She is now taking Hydromorphone (Dilaudid) 2 mg q4h prn and 6 mg hydromorph contin BID for the last 3 months and she asks for higher doses at each visit.
- You have received 3 emergency room reports (from different hospitals) showing that she has visited in "pain crises" and has received opioid analgesia.
- While you were out of the office, she has come twice to walk-in appointments while a colleague was covering -- on one visit, she stated that her moving company lost her medications during the move; on another visit, she stated that she had to give medication to her mother who had had a bad fall
- She has not returned to her work as a pharmacy technician since her ankle fusion and states she is under such pain that she "can't even think about returning".
- Her anxiety is worsening and she rarely leaves her house.
- You are concerned by her functional status, escalating opioid requirements and her attempts to acquire

more opioids.
- And by diverting her medications to another source, she has also been in breach of the opioid contract that you and her agreed upon

Learning Questions

- Is there anything that you could have done differently to try to prevent this situation?
- What can you do when opioids begin working against your patient rather than for your patient?
- How do you deal with a patient who is showing signs of opioid misuse and abuse?

Definitions

- Opioid Addiction: The continued use of opioids despite significant personal, physical and social problems associated with use. Patients exhibit both a physical dependence (withdrawal when not using) and psychological dependence (eg. craving, distress about lack of supply).
- Tolerance: Needing increased amounts of opioids to achieve the same effect, or decreased effect with continued use of the same dosage
- Withdrawal: Symptoms of opioid withdrawal symptom, or needing to take opioids to avoid withdrawal symptoms

Epidemiology

- Opioid addiction prevalence of 3.3% in patients receiving opioids for chronic non-cancer pain (Fishbain, 2008)
- Of primary care physicians surveyed in Ontario (n=658), almost all had prescribed opioids for pain in the preceding 3 months (Wenghofer, 2011)
- One in six Canadians reported using opioids between 2010 and 2011 (Watts, 2016)
- In 2009, ~ 5% of Canadians used prescription opioids non-medically including ~ 7% of 15-17 year olds, ~4% of 18-24 year olds and ~ 2% of those above age 65
- In patients admitted to the CAMH for opioid detoxification, the sources of opioids were prescriptions (37%), the street (21%), a combination of prescriptions and the street (26%), non-prescription - OTC codeine formulations (5%), and friends or family (1%) (Sproule, 2009)
- From 2005–2006 to 2010–2011, there was a 2.5X increase in the number of emergency room (ER) visits in Ontario related to narcotics withdrawal, overdose, intoxication, psychosis, harmful use and other related diagnoses (Wenghofer, 2011)
- In opioid-related deaths (n=1095) from 1991-2004, over half (56%) had received at least one opioid prescription in the 4 weeks preceding death (National Opioid Use Guideline Group, 2016)

Prevention of Opioid Misuse and Abuse

The following measures help to prevent misuse and abuse of opioids:

- Treat with non-narcotic options when at all possible. Remember that certain conditions (ie. fibromyalgia) are rarely opioid responsive and may not be of any benefit to the patient.
- Be judicious of who you prescribe opioids to. Use the Opioid Risk Tool prior to initiation of opioids. If a patient is at-risk of opioid use disorder, it doesn't mean they cannot benefit from opioid therapy. It DOES mean you must employ strategies to reduce risk.
- Taper off benzodiazepines prior to initiating opioid therapy. Benzodiazepine taper must be slow as benzodiazepine withdrawal can result in seizures and death (Ashton, 2008).
- Use an opioid contract. Advantages of the opioid contract include education of patients on the risks of aberrant opioid use and the outlining of expectations prior to treatment. Remember though - before employing the contract, you must think about the situation in which the patient breeches the contract. What will be the consequence? Dismissal from practice? Tightened dispensing?

Example of an opioid contract
http://www.rxfiles.ca/rxfiles/home/ementalhealth/ementalhealth.ca/frontend/uploads/documents/Pain-CNMP-Opioid-TreatmentAGREEMENT.pdf

- Patient education
    - Educate your patients on the goals of opioid therapy and guidelines for safe use.
    - Communicate with patients that the objective of therapy is not to remove pain entirely but to improve function lessen pain by at least 30% (on a 1-10 pain scale).
    - Inform patients it is not safe to take more than the prescribed dose
    - Advise patients to keep pills in a secure place
    - Warn patients to not mix opioids with alcohol, benzodiazepines or many over the counter products like Dimenhydrinate (Gravol©)
    - Educate family members and peers on the signs of overdose
- Schedule regular visits with individuals on chronic opioid therapy and dispense in short intervals (maximum 30 days). There is no interval too short for dispensing opioids. In special circumstances, some pharmacists may wave dispensing fees with weekly/daily dispensing. Never be afraid to “tighten the box”.
- Ask patients to keep a daily log of when they take their medication and how many pills remain and bring the log to each appointment.
- When treating chronic pain, be wary of using immediate release formulations and preferentially use extended release where possible. At least 70% of daily opioid dose should be extended release.
- Be wary of using daily doses in excess of 200 mg morphine equivalent. Beyond this value there is little evidence of improvement in pain and a higher side effect burden.
- Objectively assess a patient’s pain rating at each visit. Assess a patient’s function at each visit. If there is little pain improvement despite escalating opioid doses, taper to the most effective dose or taper to 0 and consider it a failed opioid trial. If a patient’s pain is improved but he or she continue to experience poor function, consider alternate doses or therapies.

Red flags for aberrant opioid use:

- Early renewals
- Perseveration during visit on the need for opioids
- Insistence that non-narcotics do not work
- Purported allergy to all pain medications but specific opioids
- Resistence to conversion to long-acting opioids
- Seeking appointments for narcotics toward end-of-office hours
- Losing prescriptions
- Calls after hours for pain medication and urgent appointment when primary care physician not available
- Request for immediate assessment and prescription as pressing need (for example flight, child’s soccer game) – time pressure within appointment
- Suspected “double-doctoring”
- Suspected theft of prescription pads
- Suspected diversion of opioids
- Personality changes
- Declining school or job performance
- Changes in friend networks
- Mood swings
- Worsening of co-morbid mental health disorders

**Note that some of the above behaviours (ie. Requests for early renewals) could also simply represent under-treated pain or pseudoaddiction (i.e. addiction-like behaviours that resolve with appropriate analgesia)

History and Interviewing Tips

- At every visit, assess pain with “The 5 A’s”

1. Activity	What is the effect of the opioid on the patient’s function? E.g. sitting tolerance, standing tolerance, walking ability, ability to perform activities of daily living?
2. Analgesia	How does the patient rate his or her pain over the last 24 hours, using a 0-10 scale, where 0 is no pain and 10 is the worst? Average pain? Worst pain? How much relief from the medications? 10%, 20%, 30% or more?
3. Adverse effects	Any side effects or adverse effects? Any symptoms of acute intoxication, e.g. sedation, impaired cognition, constipation? Any symptoms of withdrawal, e.g. agitation, restlessness, diarrhea?
4. Aberrant behaviours	Are medications being taken as prescribed? Any problematic behaviours such as signs of drug/alcohol use? Increasing the dose on his/her own without checking with the doctor? Pattern of lost prescriptions, early repeats or other similar behaviours?
5. Affect	Any problems with the patient’s moods, such as depression, anxiety, irritability?

- Other areas to explore might include:
    - How much per day?
    - How much do the opioids cost in a week? (useful to ask if the patient is diverting their opioids, or acquiring it on the street)
    - What formulation? (morphine, codeine, Tylenol #3, etc),
    - What route? (oral, crushed, nasal, IV)
    - Last use? (Particularly important for initiating opioid agonist therapy)
    - Tolerance? (Escalating doses required for similar effect; patients develop tolerance to the euphoric effects of opioids much more quickly than effect on pain)
    - Any effect on relationships?
    - Any accidents, injuries, risky sexual behavior or other consequences as a result of opioid use?
    - Does the patient drive or operate heavy machinery while under the influence of opioids?
- Risk factors for opioid addiction such as:
    - Family history of alcohol, substance or prescription drug abuse?
    - Personal history of alcohol, substance or prescription drug abuse?
    - Presence of pre-adolescent sexual abuse (be cautious about exploring if limited time with patient)

Differential Diagnosis (DDx)

- Psychiatric differential
    - Opioid induced mental disorders (ie. opioid induced depressive disorder)
    - Other substance intoxication (alcohol, sedative, hypnotic, anxiolytic)
    - Other withdrawal disorders (sedative, hypnotic withdrawal)
    - Pseudoaddiction (as described above)
    - Chemical coping (using opioid analgesia for psychological or spiritual distress – may be seen as on a continuum with opioid use disorder)
- Symptoms of opioid addiction may be similar to other conditions such as
    - Pancreatitis
    - Gastroenteritis
    - Benzodiazepine toxicity
    - Peptic ulcer disease
    - Viral gastroenteritis

Comorbid Diagnoses

Common comorbid conditions include:

- Psychiatric diagnoses such as
    - Anxiety conditions such as generalized anxiety disorder (GAD)
    - Post-traumatic stress disorder (PTSD)
    - Depressive disorders such as depression, seasonal affective disorder (SAD)
    - Bipolar disorders
    - Psychosis
    - Other substance use disorder
- Medical diagnoses such as
    - Chronic pain
    - Fibromyalgia
- Past history of abuse / trauma

Physical Exam

Vitals:

- Depressed respiratory rate (acute intoxication)
- Tachycardia, hypertension (withdrawal)

Skin:

- Diaphoresis, piloerection (withdrawal)
- “Track marks” – callouses following the course of a subcutaneous vein
- Nasal septum perforation (found most often in individuals who snort in opioids in addition to cocaine)1

CVS:

- New heart murmur (bacterial endocarditis)

Mental status

- Sedation, Slurred speech, Impaired cognition, Pin-point pupils (miosis) suggest acute intoxication
- Agitation, restlessness, Tearing, Yawning, Rhinorrhea, Vomiting.. Piloerection, Diaphoresis, Tachycardia, hypertension, suggests withdrawal
- Consider using tools such as the Opiate Withdrawal Scale https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf

Investigations

- Urine drug screening
    - May be used in the assessment and treatment of opioid addiction
    - If the patient can agree to random urine screens as part of their opioid contract, this may discourage use of other substances and diversion of opioids
    - It is important to inform a patient if they are providing urine for a urine drug screen in order to maintain a therapeutic alliance.
    - Interpretation must always be done in the context of the patient and results of the screen should be discussed with the patient if there are any discrepancies.
- Note that there are advantages and disadvantages to using the two main types of different urine screens:
    - Gas chromatography: Does not provide immediate results and is slightly more costly ($40), however may be preferable to immunoassay in the office setting because of significantly increased accuracy.
    - Immunoassay: Faster, and costs less ($15)

UDS	Chromatography	Immunoassay
Cost	$40 (variable)	Approx. $15 (variable)
Convenience	Done in laboratory, delay in results	Point of care
False positives	none	Possible with poppy seed ingestion, quinolone antibiotics
False negative	Improved detection of semi-synthetic and synthetic opioids Possible to ask for “no threshold” to determine if drug present at lower concentrations	Often misses semi-synthetic and synthetic opioids (oxycodone, methadone, fentanyl) Will be negative if below immunoassay threshold
Differentiation between different opioids	Yes	No
Level of cross-reactivity of other substances	Low	Cocaine - low Amphetamine/methamphetamine - high – (detects and cannot differentiate between other sympathomimetic amines eg. some OTC cold preparations)

Detection times for immunoassay and chromatography

Drug	Number of days drug is detectable	
	Immunoassay	Chromatography
Benzodiazepines (regular use)	20+ days for regular diazepam use Immunoassay does not distinguish different benzodiazepines Intermediate-acting benzodiazepines such as clonazepam are often undetected	Not usually used for benzodiazepines
Cannabis	20+	Not used for cannabis
Cocaine + metabolite	3–7	1–2
Codeine	2–5	1–2 (codeine metabolized to morphine)
Hydrocodone	2–5	1–2
Hydromorphone	2–5	1–2
Meperidine	1 (often missed)	1
Morphine	2–5	1–2: Morphine can be metabolized to hydromorphone
Oxycodone	Often missed	1–2

Caution: False Urine Samples!

- Laboratories can also provide information on which metabolites are present in urine. This can indicate by what route the substance was taken (ie. whether it was crushed or injected). Know your laboratory and which tests it performs.
- Unfortunately, some patients may provide false urine samples – either a sample from another individual or a substance other than urine.

    - Be on alert for the following characteristics as they could indicate a false sample
    - Unusually hot or cold specimen (normal range within 5 min of collection – 90-100o F)
    - Small sample volume
    - Unusual colour
    - Abnormal pH (<4.5, >8.0) – from handout from Addiction rotation handout
    - If you suspect a patient has provided you with a faulty sample, discuss your concern with the patient.

Other investigations may be clinically indicated depending on the degree of problematic use:

- CBC (screening for infection)
- Liver enzymes (ALT, AST, ALP, GGT)
- Liver function tests (bili, albumin, glucose, INR)
- Hep A, B, C serology (if Hep A, B negative consider vaccination when indicated)
- HIV serology
- Chest XR for tuberculosis (TB)

Management of Opioid Use Disorder

- Let your patient know that you are concerned about the opioid use.
- Show your concern for the well-being and function of your patient.
- Avoid an accusatory or judgmental tone, as this makes patients feel defensive.
- Ask your patient on whether or not s/he is concerned about his/her opioid use.
- Respect the patient's perspective
- Use motivational interviewing strategies
- Use harm reduction strategies such as:
    - Counsel on the importance of sterile syringes and "works" (other items used in the injection process)
    - Get to know the needle exchange programs in your community.

Management: Motivational Interviewing

- Motivational interviewing is a technique that can be used effectively and efficiently in the primary care setting, and can be done as a brief, 5-minute intervention
- Controlled clinical trials in the treatment of opioid use disorder show it has (moderate) benefit
- Basic principles of motivational interviewing:
    - Motivation to change begins with and is elicited from the patient - "People tend to believe what they hear themselves say"
    - Eliciting a patient's thoughts and intrinsic values about the merits of change is more useful than direct persuasion.
    - It is the patient that examines and resolves ambivalence about a behavior. The physician is there to guide the patient.
    - The physician/patient relationship is a partnership and not one of expert/recipient.

- Key steps for motivational interviewing

- Tip #1:
    - Use open-ended questions and assess the patient's willingness to change
    - "What do you get out of taking opioids?" – briefly touch on why the patient is continuing the behavior then quickly move to the disadvantages
    - "What do the opioids do to you and your life that you don't like?"
- Tip #2
    - Spend little time on the positive aspects of continuing the behavior and re-affirm the positive aspects of changing (reflective listening and empathy)

"It sounds like you've been under a lot of stress and the opioids provide you with some temporary relief. But, from what you said about the side effects on your mood and the way they are interfering with your performance at work, the downsides might outweigh the benefits."

- Tip #3: Amplify the positives of change
  - "What would it mean to you if you didn't feel so down and you were better able to focus at work?"
- Tip #4: Challenge the patient to problem-solve
  - "What are some other ways you could deal with stress that wouldn't come with all the nasty side effects?"
  - "What are some other ways you have dealt with stress in the past that have had more positive effects on your life?"
- Tip #5: Affirm the patient's ability to change and focus on a specific and achievable goal
  - "It sounds to me like you're thinking about reducing the opioids you're taking and I'm confident you can do it. Do you have a goal to work towards for the next time we meet? **document the patient's goal in his/her and review progress at the next meeting
- Tip #6: Show the patient that you hope things will go well
  - Re-affirm your faith in the patient's ability to change and offer him or her support
  - Give hope
  - Say "I have confidence that you can make this change. I'm here to support you in this important process."

Pharmacologic Treatment of Opioid Use Disorder

- There are different options in the pharmacologic treatment of opioid use disorder which include:
  - Opioid taper
  - Opioid substitution therapy (OST)
  - Opioid antagonist therapy
  - Non-substitutive treatment of withdrawal symptoms.

Opioid Taper

- When to consider tapering (generally):
  - Concern about problematic opioid use
  - Depressed mood, sleep apnea, sedation
  - Inadequate pain relief despite 2-3 different opioids tried
- When to be cautious about tapering:
  - During pregnancy (acute withdrawal may cause spontaneous abortion, premature labour)
  - Comorbid psychiatric conditions or medical conditions worsened by anxiety
  - When patients are obtaining opioids from multiple sources (best managed in opioid treatment program)
  - When patient is snorting or injecting opioids
- Tips for Opioid Tapering
  - Schedule frequent f/u visits and frequent dispensing intervals (2 weeks or less)
  - Use controlled release formulations when possible
  - Emphasize scheduled over prn doses
  - Maintain a daily dosing schedule: decrease the dose before decreasing frequency
  - Switch to morphine (if on oxycodone or hydromorphone)
  - Tolerance to one opioid may not be fully transferred to another so start your patient on 50-75% of equivalent dose
  - Monitor for withdrawal using the COWS tools
  - Rate of taper
    - Decrease in 10% increments (the time of the increment depends on duration of opioid use – if weeks to few months, may decrease by 10% daily – if longer duration of use, decrease by 10%

q 1-3 weeks)

- Continue 10% incremental taper until 1/3 of original dose then slow the taper to 5% incremental decrease over same time period

Opioid Substitution Therapy (OST)

Therapy	Methadone	Buprenorphine
Class	Full opioid agonist	Partial opioid agonist
Mechanism	Opioid replacement therapy – long acting agonist at mu receptors Decreases withdrawal symptoms and cravings	Opioid replacement therapy - Agonist of mu receptors at low doses (behaves as antagonist at high doses) Often combined with naltrexone (not absorbed sublingually) to reduce abuse potential Decreases withdrawal symptoms and cravings
Route	PO liquid	Sublingual tablet
Convenience	Taken daily in supervised setting	Taken daily in supervised setting Take-home doses may be permitted eventually
Population	Delivered in structured settings often with counseling and medical services **thus may be advisable for socially unstable patients Preferable for heroine addiction May be more efficacious with concurrent cocaine addiction	Can be delivered in structural setting but patients can be graduated to take-home dosing Buprenorphine alone in pregnancy may decrease risk of neonatal abstinence syndrome (as compared to methadone) Very good choice for younger patients or patients with short history of use (<4 years)
Side effects	Withdrawal symptoms, dysphoria	Milder withdrawal symptoms, dysphoria
Safety risks	CNS depression, QT prolongation, arrhythmias, hypotension, respiratory depression, overdose potential	Respiratory depression (though clinically negligible because partial mu agonist), lower overdose potential
Pregnancy risk category	C – most studied opioid replacement in pregnant women	C - generally buprenorphine alone (without naltrexone) used in pregnancy
Evidence	Strongest evidence base for efficacy in reducing opioid use and retaining patients in treatment19	More effective than placebo for treatment retention though may be less effective than methadone for treatment retention when prescribed at doses less than 7 mg daily and with flexible dosing19

Cost of 7-day supply of mean dose	$25-50	$50-75
Who can prescribe	Physicians with special exemption from Controlled Drugs and Substances Act http://www.cpso.on.ca/cpso-members/methadone-program	All physicians though additional training as recognized by the provincial college and experience with initiation strongly recommended21

Opioid antagonist therapy

- Naltrexone
  - Competitive opioid antagonist that induces withdrawal and renders further opioid ingestion ineffective. When used alone, there is no statistically significant difference between it and placebo. However, it may be appropriate in very motivated patients. Be aware and counsel your patients that there is overdose potential with discontinuation of naloxone as patients may respond to lower doses of opioids than previously.

Symptomatic relief

The following are examples of medications that can be used to treat withdrawal symptoms:

- Sympathetic symptoms:
  - Clonidine (see Opioid Withdrawal protocol for dosing)
- Diarrhea:
  - Loperamide 4 mg PO initial dose then 2 mg PO after each loose stool to maximum of 16 mg/day
- Nausea:
  - Dimenhydrinate: 50-100 mg PO q 4-6h to maximum of 400 mg/day prn
  - Prochlorperazine: 5-10 mg PO q4h prn
- Myalgias:
  - Acetaminophen: 325-650 mg PO q4h prn,
  - Naproxen: 500 mg PO with meals then BID prn
- Insomnia:
  - Trazadone 25-100 mg PO qhs prn
- Anxiety, dysphoria, lacrimation, rhinorrhea:
  - Hydroxyzine 25-50 mg PO TID prn

When to Refer

- Consider referring if there is a:
  - Need for opioid substitution therapy (if physician not personally trained) or concurrent cocaine or other substance use disorder
  - Concurrent disorder (other Axis I psychiatric diagnosis such as depression, anxiety, or another substance use disorder)
  - Need for medical detoxification from concurrent alcohol, benzodiazepine or barbiturate use, as thisshould be done carefully in supervised setting
  - Interest from the patient in formal outpatient, or residential drug treatment

Where to Refer in Ontario

- Directory of OST providers across Ontario
  - http://www.opiateaddictionresource.com/

- http://dart.on.ca

Where to Refer in Ottawa, ON

- Substance Use and Concurrent Disorders Program ROH – outpatient and inpatient programs, detox, maintenance and aftercare program options - 613.722.6521 ext 6224
- Recovery Ottawa – outpatient methadone, suboxone and naltrexone treatment – 613.680.7444
- OASIS – opioid substitution therapy and extensive multidisciplinary programming – 613.789.6309
- OATC: Ontario Addiction Treatment Centres http://www.oatc.ca/
- Methadone and suboxone outpatient therapy - 613-233-1114
- Drug and Alcohol Registry of Treatment 1-800-565-8603. Provides HCPs with a range of treatment options suited to the patient.
- Substance Abuse and Concurrent Disorders Program ROH – outpatient and inpatient programs, detox, maintenance and aftercare program options - 613.722.6521 ext 6224 www.theroyal.ca
- Centre for Addiction and Mental Health Addiction Services – Addiction Clinical Consultation service – 1.888.720.2777 Available to Ontario social and health professionals – reply in 4 business hour
- Substance Abuse and Concurrent Disorders Program ROH – outpatient and inpatient programs, detox, maintenance and aftercare program options - 613.722.6521 ext 6224 www.theroyal.ca
- Ottawa Withdrawal Management – Short-term residential withdrawal management with 24 hour supervision – 613.241.1525
- OAARS – Ottawa Addiction Access and referral service – triage program - 613-241-5202 http://montfortrenaissance.ca/en/

Case, Part 2

- You try to start a discussion with O. regarding your concern about her problematic use of opioids.
- Despite your empathetic approach, she becomes very upset and leaves your office abruptly.
- A few days later she schedules another appointment to continue the discussion. You employ brief motivational interviewing strategies.
- She states she is very fearful of experiencing severe pain without opioids but also notes that her opioids “are beginning to work against” her.
- She also notices that she is using them more and more to combat loneliness and for the purpose of controlling anxiety.
- After a long discussion, you and O.P. plan to start attempt an opioid taper with close follow-up.

1. Which of the following drugs may be used to reverse an opioid overdose?

- ○ Hydroxyzine
- ○ Naproxen
- ○ Methadone
- ○ Naloxone
- ○ Flumazenil

2. Signs of opioid withdrawal typically may include all of the following EXCEPT:

- ○ Diaphoresis
- ○ Agitation
- ○ PIloerection
- ○ Bradycardia

- Vomiting

Readings for Patients

- Patient handout: Opioid Information for patients: Information and safety advice for patients. Web: http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b04.html
- Patient video: Mike Evans has a “Best advice for people taking opioid medication” video https://www.youtube.com/watch?v=7Na2m7lx-hU
- The Mindfulness Workbook for Addiction: A Guide to Coping with the Grief, Stress and Anger that Trigger Addictive Behaviors by Rebecca E. Williams, Julie S. Kraft
- Opiate Addiction - The Painkiller Addiction Epidemic, Heroin Addiction and the Way Out – Taite Adams
- The Recovery Formula: An Addict's Guide to getting Clean & Sober Forever – Beth Burgess
- An introductory Guide to NA
- The Addiction Recovery Skills Workbook: Changing Addictive Behaviors Using CBT, Mindfulness, and Motivational Interviewing Techniques – Suzette Glasner-Edwards

Resources for Physicians

- CAMH Opioid Misuse and Addiction Toolkit https://www.porticonetwork.ca/web/opioid-toolkit
- Opioid Manager (McMaster University) http://nationalpaincentre.mcmaster.ca/opioidmanager/opioid_manager_download.html
- CME module: suboxonecme.ca
- Opioid Treatment Agreement: http://www.rxfiles.ca/rxfiles/home/ementalhealth/ementalhealth.ca/frontend/uploads/documents/Pain-CNMPOpioidTreatmentAGREEMENT.pdf
- Opioid Risk Tool: http://www.lynnwebstermd.com/opioid-risk-tool/
- Screener and Opioid Assessment for Patients with Pain – determines how much monitoring a patient on long term opioid therapy requires http://nhms.org/sites/default/files/Pdfs/SOAPP-14.pdf
- Addiction Behaviours Checklist https://www.nhms.org/sites/default/files/Pdfs/Addiction_Behaviors_Checklist-2.pdf
- Current Opioid Misuse Measure http://nationalpaincentre.mcmaster.ca/documents/comm_sample_watermarked.pdf
- CAGE-AID http://www.integration.samhsa.gov/home/ementalhealth/ementalhealth.ca/frontend/images/res/CAGEAID.pdf
- Clinical Opioid Withdrawal Scale https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf
- Withdrawal Protocol https://www.saskatoonhealthregion.ca/locations_services/Services/mhas/Documents/Resources%20for%20Professionals/Opioidwithdrawalprotocol-finaldraftJan14-2010_000.pdf
- CPSO Statement on Methadone Maintenance Treatment: http://www.cpso.on.ca/Policies-Publications/Policy/Methadone-Maintenance-Treatment-for-Opioid-Depende
- Encouraging Patients to Change Unhealthy Behaviors With Motivational Interviewing. Elizabeth E. Stewart, PhD, and Chester Fox, MD. Fam Pract Manag. 2011 May-June;18(3):21-25.

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About this Document

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