Pain in Dual Diagnosis Patients

Boundary Defining Risk Assessment

Dr. Przemyslaw Pietucha
CCFP (Anesth)
Disclosure

- WSIB
  - Substance Management Treatment Program
CASE

- Lets Meet Dave.....
“Pain is the most common complaint for which individuals seek medical attention!”

Definitions Related to the Medical Use of Opioids: Evolution Towards Universal Agreement
Seddon R. Savage
Prevalence of pain

- Approximately 50-70 million people in the United States have pain.
- About 10% of the American population have addictive disorders.
- Therefore, based on the statistics, as many as 5-7 million patients with the disease of addiction also have pain.

Universal precautions in pain medicine: a rational approach to the treatment of chronic pain
DL Gourlay, HA Heit... - Pain Medicine, 2005 - Wiley Online Library
Multidimensional Assessment for Persistent Pain

- Pain history
- History of past health relevant to the presenting problem
- Psychiatric comorbidity
- Psychosocial factors
- Risk of addiction
- Assessment of function
- Goals
- Physical examination
- Followup visit

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Pain history

- Brief Pain inventory (BPI)
- Douleur Neuropathique 4 (DN-4)
- McGill Pain Questionnaire

Brief Pain Inventory (Short Form) - Modified

Name DAVE Date NOV26 2011

On the diagram below, colour in the areas where you feel pain. Label the most painful area with the number 1, the second most painful with the number 2. (Black=sharp/stabbing, Red=burning, Blue=numbness, Green=pins and needles, Yellow=aching, Arrows = shooting pain.)
DN-4

- Neuropathic Pain
- Good validation
- Comprised of 10 items (7 symptoms and 3 clinical examinations)
- Score of 4 or more classifies the pain as neuropathic.
- The DN4 has a higher sensitivity (83%) and specificity (90%) than other tools described.
DN4 – QUESTIONNAIRE

To estimate the probability of neuropathic pain, please answer yes or no for each item of the following four questions.

**INTERVIEW OF THE PATIENT**

<table>
<thead>
<tr>
<th>QUESTION 1:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the pain have one or more of the following characteristics?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Burning</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Painful cold</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Electric shocks</td>
<td>☑</td>
<td></td>
</tr>
</tbody>
</table>

**QUESTION 2:**

<table>
<thead>
<tr>
<th>QUESTION 2:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the pain associated with one or more of the following symptoms in the same area?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Tingling</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Pins and needles</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Numbness</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Itching</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

**EXAMINATION OF THE PATIENT**

<table>
<thead>
<tr>
<th>QUESTION 3:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the pain located in an area where the physical examination may reveal one or more of the following characteristics?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Hypoesthesia to touch</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Hypoesthesia to pinprick</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

**QUESTION 4:**

<table>
<thead>
<tr>
<th>QUESTION 4:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the painful area, can the pain be caused or increased by: Brushing?</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

**Patient’s Score:** 4/10

YES = 1 point
NO = 0 points
Multidimensional Assessment for Persistent Pain

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PHQ-9 and GAD-7

- Two quick tools to use quickly in office
- Both Validated
- For today only PHQ-9
The Patient Health Questionnaire (PHQ) is designed to facilitate the recognition and diagnosis of the most common mental disorders in primary care patients. For patients with a depressive disorder, a PHQ Depression Severity Index score can be calculated and repeated over time to monitor change.

http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/
# Dave's PHQ-9

## PHQ-9

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?  
(Use "✓" to indicate your answer)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*(For office coding: Total Score: 16 = 2 + 10 + 3)*

If you checked off any problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

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From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission.
Multidimensional Assessment for Persistent Pain

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Addiction:

A primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations.
The 5 C’s

- Chronic use
- Impaired Control over drug use
- Compulsive use
- Continued use despite harm
- Craving
Predicting Aberrant Behaviours in Opioid-Treated Patients

Predicting Aberrant Behaviors in Opioid-Treated Patients: Preliminary Validation of the Opioid Risk Tool Lynn R. Webster MD, Rebecca M. Webster
Pain Medicine Volume 6, Issue 6, pages 432-442
Tools

- ORT - Opioid Risk Tool
- CAGE- AID – basic
- SOAPP - Screener and Opioid Assessment for Patients with Pain
- COMM - Current Opioid Misuse Measure

http://www.painedu.org/
**ORT**

- **Purpose:** assesses the risk of aberrant behaviors when patients are prescribed opioid medication for chronic pain
- **Target population:** Adults
- **Evidence:**
  - Provides excellent discrimination between high risk and low risk patients (Passik et al. 2008)
  - Exhibited a high degree of sensitivity and specificity for determining which individuals are at risk for opioid abuse (Webster & Webster 2005).
  - Patients categorized as high-risk on the ORT have an increased likelihood of future abusive drug-related behavior (Chou et al. 2009).
# Opioid Risk Tool (ORT)

**Physician Form**

*With Item Values to Determine Risk Score*

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dave</td>
<td>Nov 25/11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mark each box that applies</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family history of substance abuse</td>
<td>- Alcohol [ ] 1 [ ] 3</td>
<td>- Alcohol [ ] 3</td>
</tr>
<tr>
<td></td>
<td>- Illegal drugs [ ] 2 [ ] 3</td>
<td>- Illegal drugs [ ] 4 [ ] 4</td>
</tr>
<tr>
<td></td>
<td>- Prescription drugs [ ] 4</td>
<td>- Prescription drugs [ ] 5</td>
</tr>
<tr>
<td>2. Personal history of substance abuse</td>
<td>- Alcohol [ ] 3 [ ] 3</td>
<td>- Alcohol [ ] 4 [ ] 4</td>
</tr>
<tr>
<td></td>
<td>- Illegal drugs [ ] 4 [ ] 4</td>
<td>- Illegal drugs [ ] 5</td>
</tr>
<tr>
<td></td>
<td>- Prescription drugs [ ] 5</td>
<td>- Prescription drugs</td>
</tr>
<tr>
<td>3. Age (mark box if 16-45 years)</td>
<td>[ ] 1</td>
<td>[X] 1</td>
</tr>
<tr>
<td>4. History of preadolescent sexual abuse</td>
<td>[ ] 3</td>
<td>[ ] 0</td>
</tr>
<tr>
<td>5. Psychological disease</td>
<td>- Attention-deficit/ hyperactivity disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia [ ] 2 [ ] 2</td>
<td>- Depression [ ] 1 [X] 1</td>
</tr>
</tbody>
</table>

Low (0-3) Moderate (4-7) High (≥8) Scoring totals [ ] 12
<table>
<thead>
<tr>
<th>Low risk for Misuse (Green Light)</th>
<th>Moderate risk for Misuse (Yellow Light)</th>
<th>High risk for Misuse (Red Light)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Opioid Risk Tool score: 0-3</td>
<td>• Opioid screening tool score: 4-6</td>
<td>• ORT 7 or above</td>
</tr>
<tr>
<td>• Utilize all treatment options, including opioids if appropriate</td>
<td>• Consider a consultation with an expert, if available</td>
<td>• Co-management with an expert if available</td>
</tr>
<tr>
<td>• When stable, follow-up every 3 months</td>
<td>• Opioids can still be used in this population but require more monitoring processes in place</td>
<td>• Written opioid agreement</td>
</tr>
<tr>
<td>• Part-fill opioids monthly</td>
<td>• Consider reducing quantity dispensed and more frequent monitoring</td>
<td>• Part-fills 1-2 times weekly</td>
</tr>
<tr>
<td>• Continue to monitor and check for ambiguous drug behaviours</td>
<td>• Consider signed opioid agreement</td>
<td>• UDTs twice monthly</td>
</tr>
<tr>
<td>• Use UDT as required</td>
<td>• Consider urine drug screening 3-4 x per year</td>
<td>• Ongoing participation in addiction recovery activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More monitoring and control than most family physicians wish to manage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A list of Canadian pain clinics can be found at:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• <a href="http://www.canadianpaincoalition.ca">www.canadianpaincoalition.ca</a></td>
</tr>
</tbody>
</table>
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- Physical examination
- Follow-up visit
Assessment of function

- **BPI**
  - Scale out of 70
  - Can be used to track progress and response to treatment
Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

1. **General Activity:**
   - Does not interfere: 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

2. **Mood:**
   - Does not interfere: 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

3. **Walking Ability:**
   - Does not interfere: 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

4. **Normal Work (includes both work outside the home and housework)**
   - Does not interfere: 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

5. **Relations with other people:**
   - Does not interfere: 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

6. **Sleep:**
   - Does not interfere: 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

7. **Enjoyment of Life:**
   - Does not interfere: 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

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0/70 No disability, 70/70 Total Disability

*With permission: Pain Research Group, MD Anderson Cancer Center, 1997*
Multidimensional Assessment for Persistent Pain

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- Assessment of function
- **Goals**
- Physical examination
- Followup visit
Treatment Specific Outcome

- S.M.A.R.T Goals
  - Specific
  - Measurable
  - Achievable
  - Relevant/Realistic
  - Timely

Dave’s SMART Goals

- Walk for 30 min with tolerable pain in 6 weeks time
- Sit for 30 min while working by 6 weeks
- Start going to the gym 3 x week for 1 hour by 6 weeks time
- Throw away reminders of recent failed relationship by 6 weeks
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Plan…Day 1

- Initiate Opiate Therapy
- Opioid Treatment Agreement (OTA)
- Initiate antidepressant
- Routine labs for depression
- Random Urine Drug screen (UDT) x 1 at start. Shows Gravol/Advil/Oxycodone
- EKG
- Non urgent CT scan
- Call pharmacy to validate he gets his Rx at and confirmed Percocet dose
Plan…Day 1

- You start Duloxetine 30 mg x 2 weeks then increase the dose to 60 mg over the following 2 weeks.
- Initiate Mobicox 15 mg daily and stop the ibuprofen.
- Trazadone 25 mg qhs PRN for sleep.
- Percocet is stopped and the patient is initiated on:
Choice of Opiate?

- Recommend no combination products
- Dave is taking about 10 x 5 mg Oxycodone /day = 50 mg
- Morphine equivalent = 75 mg
- You start Long acting morphine at 20 mg BID + give him assess to 20 mg of IR per/day for breakthrough pain
- Bimonthly dispensing
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Follow up: The 5 A’s

Opioid Risk Manager

- Analgesic response both to pain score and function
- Activity response
- Adverse events (to treatment)
- Aberrant drug--related behavior
- Action Plan – new
Plan at 1 month

- Increased dose of LA Morphine to 30 mg BID with 2 doses a day of IR 5 mg Morphine, for breakthrough
- Return in 1 month for UDT
Tighten the Boundaries…

Dave to come back for a Pill count
Current Opioid Misuse Measure (COMM)

- Butler et al. (2007)
- Created to monitor patients who are already using opioid therapy
- Questions were created to measure behaviour over a period of 30 days
- Covers six concepts: Poor response to medication, Signs/symptoms of drug misuse, Evidence of lying and drug use, Emotional problems/psychiatric issues, Medication misuse/noncompliance, and Appointment patterns
Dave scored 10

- >9
  - 77% change of substance misuse
Plan at 2 months

- LA Morphine increased to 40 mg BID with no doses for breakthrough dosing at this time.
- A discussion was had with patient re: exit strategy @ about 6 months time and agreement was abridged.
- New SMART goals
  - For continued treatment and referred to physiotherapy
  - Refer to Psychiatry
Plan at 6 months

- Still no referral time for psychiatry, you call urgently in light of decompensation
- Refer to a Mindfulness Stress Reduction clinic
- You consult with Dave to add another medication beyond the opiate called Lyrica
- You also increase his Morphine LA to 50 mg BID.
- You order an MRI for further clarification
Tighten the Boundaries...

- Weekly Rx given at this time
- Increase UDT screen (Dave to drop off one sample per week)
What is happening here?

- Poor pain control
- Dependence
- Tolerance
- Addiction
- Pseudotolerance /Chemical Coper?
- Pseudoaddiction
- Other disease process?
Physical dependence:

A state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.
Physical dependence and addiction can coincide, but physical dependence does not equal addiction in all cases. Physical dependence is a neuropharmacological phenomenon while addiction is both a neuropharmacological and behavior phenomenon.

Tolerance

- A state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug’s effects over time.
Pseudotolerance

The need to increase dosage that is not due to tolerance, but due to other factors:

- disease progression
- new disease
- increased physical activity
- lack of compliance
- change in medication
- drug interaction
- addiction
- Deviant behavior

Pseudoaddiction

The patient who seeks additional medications appropriately or inappropriately secondary to significant under-treatment of the pain syndrome. When the pain is treated in the proper manner, all inappropriate behavior ceases.
Addiction versus Pseudoaddiction

- **Addiction**
  - Prospective
    - Patient’s behavior and compliance with treatment becomes aberrant despite “rational pharmacology”

- **Pseudoaddiction**
  - Retrospective
    - Patient’s behavior and compliance with treatment normalizes with “rational pharmacology”

Universal precautions in **pain medicine**: a rational approach to the treatment of chronic pain
DL Gourlay, HA Heit... - *Pain Medicine, 2005* - Wiley Online Library
Plan at 8 Months....

- You rationalize his meds once again hoping to be proven wrong.
- You increase the Morphine to 100 mg BID, Lyrica 300 mg BID, Duloxetiné 90 mg OD
- Boundaries are tightened once again
Tighten the Boundaries…

- Dispense 2 times a week
- Witnessed once UDT per week at your clinic
- Your nurse practitioner now helps to do pill counts more often
<table>
<thead>
<tr>
<th>PAIN</th>
<th>Addiction</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Not out of Control with Meds</td>
<td>I. Out of Control</td>
</tr>
<tr>
<td>II. Meds improve quality</td>
<td>II. Meds impact quality of life</td>
</tr>
<tr>
<td>III. Decrease meds if side effects present</td>
<td>III. Despite side effects meds continue or increase</td>
</tr>
<tr>
<td>IV. Physical problem concerns</td>
<td>IV. Denial about problem</td>
</tr>
<tr>
<td>V. Follows agreement</td>
<td>V. Does not follow agreement</td>
</tr>
<tr>
<td>VI. Left over meds</td>
<td>VI. No left over meds, loses Rx’s and always has a story</td>
</tr>
</tbody>
</table>

Boundary Defining Moments

- Despite rational pharmacotherapy and supportive treatment there has been no improvement in his aberrant behaviors and pain state.

- You have ruled out pseudotolerance and pseudoaddiction as a diagnosis.
Plan for 10 months

- You tell Dave your concerns.
- Dave tells you he is very sorry. But he is loosing control. He is not sure what is happening anymore.
- He refer him to a specialized addiction clinic at CAMH
Tighten the Boundaries…
Dual Diagnosis
Serenity Prayer

God grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference.
I. Illegal or Criminal Behavior

- Diversion
- Prescription forgery
- Stealing or “borrowing” drugs from others
II. Dangerous Behavior

- Motor vehicle crash/arrest related to opioid or illicit drug or alcohol intoxication or effects
- Intentional overdose or suicide attempt
- Aggressive/threatening/belligerent behavior in the clinic
Behavior that Suggests Addiction

- Use in an unapproved or inappropriate manner (such as cutting time-release preparation, injecting oral formulations and applying fentanyl topical patches to oral or rectal mucosa)
- Obtaining opioids outside of medical settings
- Concurrent abuse of alcohol or illicit drugs
- Repeated requests for dose increases or early refills, despite the presence of adequate analgesia
Behavior that Suggests Addiction

- prescription “loss”
- seeking prescriptions from other clinicians or from emergency rooms without informing prescriber, or after warnings to desist
- deterioration in the ability to function at work, in the family, or socially, which appears to be related to drug use
- resistance to changes in therapy despite clear evidence of adverse physical or psychological effects from the drug
- Positive urine drug screen-other substance use
Aberrant Behavior that Requires Attention

- Reporting psychic effects not intended by the clinician
- Resistance to a change in therapy associated with “tolerable” adverse effects, with expressions of anxiety related to the return of severe symptoms
- Missing appointment(s)
- Not following other components of the treatment plan (physical therapy, exercise, etc.)
Aberrant Behavior that Requires Attention

- Aggressive complaining about needing more of the drug
- Drug hoarding during periods of reduced symptoms
- Requesting specific drugs
- Openly acquiring similar drugs from other medical sources
- Unsanctioned dose escalation or other noncompliance with therapy on one or two occasions
- Unapproved use of the drug to treat another symptom
Questions?

“There are a lot of things you can do to fill your time, Ma. Have you thought about a hobby or an addiction?”
Pain Assessment and Risk Management Tools and Resources

Dr Przemyslaw Pietucha, Ontario Scientific Assembly 2012

- BPI
- PHQ-9 http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/
- Urine Drug Testing (UDT) Resources
- SOAPP-R http://www.painedu.org/soap.asp
- COMM http://www.painedu.org/soapp.asp
- Opioid Risk tool (ORT)
  - Physician Scoring: http://www.viha.ca/NR/rdonlyres/8AF0014E-06D5-4D1A-B922-BD3F985C9B00/0/201011038RiskToolOpioidRiskToolClinicianForm.pdf
- Opioid Manager
- SMART Goals Worksheet
- Sample Opioid Treatment Agreements
- Resource Websites
- Opioid Risk Management
- Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain
  - http://nationalpaincentre.mcmaster.ca/opioid/
- Department of Veteran Affairs: Opioid Chronic Pain Guidelines: Aberrant Behaviors & Predictors of Opioid Misuse
  - http://www.healthquality.va.gov/Chronic_Opioid_Therapy_COT.asp