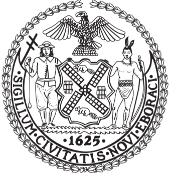

City Health Information

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Judicious Prescribing of Opioid Analgesics*

- Providers can reduce patient risks associated with opioid analgesics, including fatal drug overdose.
- For acute pain:
  - If opioids are warranted, prescribe only short-acting agents.
  - A 3-day supply is usually sufficient.
- For chronic noncancer pain:
  - Avoid prescribing opioids unless other approaches to analgesia have failed or are contraindicated.
- Avoid prescribing opioids to patients taking benzodiazepines because of the risk of fatal respiratory depression.
- Reassess pain status and treatment plan when the opioid dose is ≥90 total daily morphine milligram equivalents (MME).

*The guidance in this document is not intended for end-of-life care.

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In 2016, unintentional drug poisoning (overdose) rates in NYC increased for the sixth consecutive year.[1]

- There were 1,374 unintentional drug overdose deaths in NYC in 2016, compared with 937 in 2015, an increase of 437.[1]
- From 2000 to 2016, the number of overdose deaths involving opioid analgesics increased fourfold, from 55 in 2000 (New York City Health Department/Office of the Chief Medical Examiner, unpublished data) to 241 in 2016.[1]
- In 2016, more than one New Yorker died every other day due to an opioid analgesic overdose.[1]

Reduce the risk of opioid analgesic-related harms: prescribe opioids judiciously and ensure patients understand the benefits and risks, including opioid use disorder (OUD), also known as addiction, and fatal overdose (**Boxes 1-3**[2-20]).

Evaluate all patients reporting pain with a physical examination and a history that includes medication history and pain onset, location, quality, and duration.[21] Attempt to determine the cause and mechanism of the pain (neuropathic, inflammatory, muscle, or mechanical/compressive) to guide appropriate first-line nonopioid treatment (**Box 4**[22-31]).

PRESCRIBE OPIOIDS JUDICIOUSLY

Prescribe opioids only when you have weighed the risks and benefits of opioid therapy. Avoid prescribing opioids unless first-line modalities are unlikely to be effective, have failed,[32,33] or are contraindicated.

Consistently apply universal precautions for all patients whenever opioid therapy is initiated, continued, or modified. This practice will reduce stigma for individual patients, optimize pain management, and protect patients, providers, and the public's health.[34-37]

USE UNIVERSAL PRECAUTIONS

Assess pain and functional status

Assess pain and functional status with validated tools, such as Three-Item Pain, Enjoyment and General Activity (PEG),[38] and then perform a physical exam. See **Resources for Providers** for more options.

Take a medication history

Assess the patient's medications to avoid harmful interactions. *Avoid prescribing opioids to patients taking benzodiazepines because of the increased risk of fatal respiratory depression.*[15-17]

BOX 1. RISKS ASSOCIATED WITH OPIOID ANALGESICS[2-17]

Health risks
- Physical dependence
- Tolerance
- Opioid use disorder
- Respiratory depression[a]
- Fatal and nonfatal overdose[a]
- Falls and injury, especially in older adults

Side effects
- Sexual dysfunction and other endocrine effects
- Drowsiness
- Constipation
- Nausea/vomiting
- Chronic dry mouth
- Dry skin/itching/pruritus
- Increased pain sensitivity (hyperalgesia)

[a]Risks of respiratory depression and overdose increase when opioids are combined with other central nervous system depressants (eg, benzodiazepines).

Assess for unhealthy substance use and mental health conditions

Screen all patients for unhealthy substance use and mental health conditions before initiating opioid therapy (**Boxes 5** and **6**[39-44]). Patients with a history of substance use disorder are at increased risk for opioid misuse, opioid use disorder, and fatal opioid overdose.[45-47]

Depression, anxiety, and posttraumatic stress disorder often coexist with chronic pain[48-50] and may increase the risk of opioid misuse[49,50] or interfere with improvement of pain and function.

Use the lowest effective opioid dose for the shortest duration

Start all patients at the lowest possible effective dose of short-acting/immediate-release opioids for no longer than you expect pain severity to warrant opioids. For patients

BOX 2. PHYSICAL DEPENDENCE, WITHDRAWAL, TOLERANCE, MISUSE, AND OPIOID USE DISORDER[2,18-20]

Physical dependence (may occur within ≤7 days of treatment)
- Physiologic adaption to chronic opioid exposure resulting in signs and symptoms of withdrawal after abrupt opioid cessation, rapid dose reduction, or administration of an opioid antagonist (eg, naloxone).
- Causes drug-specific **withdrawal syndrome** if drug use is abruptly ceased. Opioid withdrawal syndrome includes
  - restlessness, irritability
  - abdominal pain
  - diarrhea
  - dysphoric mood
  - nausea or vomiting
  - muscle aches
  - lacrimation or rhinorrhea
  - pupillary dilation, piloerection, or sweating/yawning
  - insomnia

Tolerance: either
- Need for markedly increased amounts of opioids to achieve the same analgesic or other desired effect

  or
- Markedly diminished effect with continued use of the same amount of an opioid.

Misuse
- Opioid use contrary to the directed or prescribed pattern of use, regardless of the presence or absence of harm or adverse effects.
- May or may not be associated with physical dependence.
- Signs may include pattern of early refills; prescription problems such as lost, spilled, or stolen medications; and escalating opioid use in the absence of a prescriber's direction.

Opioid use disorder (OUD) (addiction)
- Problematic pattern of opioid use leading to clinically significant impairment or distress, defined by specific criteria (**Box 3**).

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needing higher doses of opioids and/or on chronic opioid therapy, calculate the morphine milligram equivalent dose (MME) to avoid total dose of ≥90 MME/day (**Box 7**).[51-53]

Avoid prescribing opioids to patients taking benzodiazepines

Benzodiazepines increase the risk of fatal overdose when taken in combination with opioid analgesics.[15-17] See Judicious Prescribing of Benzodiazepines for additional guidance.

BOX 3. OPIOID USE DISORDER—DSM-5 CRITERIA[2]

Opioid use disorder may be diagnosed if 2 or more of the following criteria are met:

1. Taking the opioid in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the opioid
4. Craving or a strong desire to use opioids
5. Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use of opioids in physically hazardous situations
9. Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
10. Tolerance (**Box 2**)[a]
11. Withdrawal (**Box 2**)[a]

2-3 criteria: mild opioid use disorder
4-5 criteria: moderate opioid use disorder
6 or more criteria: severe opioid use disorder

[a]This criterion is not considered to be met for individuals taking opioids solely under appropriate medical supervision.

BOX 4. EXAMPLES OF NONOPIOID APPROACHES TO MANAGING PAIN[22-31]

Nonpharmacologic therapies

- Behavioral treatment (eg, cognitive behavioral therapy)
- Self-management therapies (eg, mindfulness, meditation, relaxation)
- Physical treatments (eg, exercise therapy, yoga, weight loss)
- Complementary health approaches (eg, acupuncture)

Nonopioid medications

- Oral analgesics (acetaminophen, ibuprofen)
- Anti-inflammatory agents (eg, nonsteroidal anti-inflammatory drugs [NSAIDs])
- Selected anticonvulsants and antidepressants (tricyclic, gabapentin, pregabalin, etc)
- Corticosteroids (oral or injected)
- Topical agents

Consult the Prescription Monitoring Program

As of August 2013, practitioners are required to review the New York State Prescription Monitoring Program (PMP) prior to prescribing a controlled substance listed on schedules II, III, or IV.[54] The PMP provides quick, confidential, 24/7 access to your patients' controlled substance prescription dispensing history.

BOX 5. UNIVERSAL SCREENING FOR UNHEALTHY SUBSTANCE USE

- Routinely screen all your patients for unhealthy substance use, including opioid misuse.
- In a nonjudgmental tone, explain that you routinely ask all of your patients about these issues.
- Use validated instruments to screen patients for unhealthy substance use (**Resources**).
- Provide brief intervention based on screening results; offer treatment and referral to specialty care when appropriate.

See Addressing Alcohol and Drug Use—An Integral Part of Primary Care for further guidance.

BOX 6. PAIN AND MENTAL HEALTH[39-44]

- Use validated instruments to screen for common mental health conditions:
  - Patient Health Questionnaire (PHQ-2 or PHQ-9) to assess depression (see Detecting and Treating Depression in Adults)
  - Generalized Anxiety Disorder (GAD-2 or GAD-7) screen for generalized anxiety, panic, and posttraumatic stress disorder (see Clinical Guidelines for Adults Exposed to the World Trade Center Disaster)
- Offer appropriate treatment to help improve overall pain outcomes.

BOX 7. MORPHINE MILLIGRAM EQUIVALENT DOSES (MME)[51-53]

- MME describes an opioid's strength relative to morphine. For example, 30 mg hydrocodone = 30 MME, 20 mg oxycodone = 30 MME, and 300 mg tramadol = 30 MME.
- There is a significantly increased risk for fatal overdose at ≥90 MME/day. If dosing does reach ≥90 MME/day, thoroughly reassess the relative risks and harms versus pain and functional benefits, and consider reducing the dose if unfavorable.
- Use OpioidCalc (iOS or Android app, or desktop version), a tool to calculate a patient's total daily MME and help identify risk for fatal overdose.

Visit the New York City Health Department Opioid Prescribing page for the downloadable OpioidCalc and other resources.

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If the PMP shows that your patient has recently filled multiple prescriptions written by different providers and/or filled at different pharmacies, take steps to promote their safety (**Box 8**[2,55]).

COUNSEL THE PATIENT

Counsel your patient about the risks of opioid use (**Box 9**[34,51,56,57]).

FOR ACUTE PAIN

For patients with acute pain:

- Apply universal precautions.
- Prescribe a 3-day or less supply. A 3-day supply is usually sufficient. In New York State, providers can prescribe no more than a 7-day supply of opioids for initial treatment of acute pain,[58] although 7 days of opioid treatment is rarely needed.
- Use short-acting/immediate-release opioids and avoid long-acting/extended-release opioids.[59]

FOR POSTOPERATIVE PAIN[57]

In opioid-naïve patients, many surgical procedures are associated with an increased risk of chronic opioid use in the postoperative period.[60,61] Reserve the use of opioids for severe acute pain, and when nonopioid therapies will not provide adequate relief.[57,62]

- Evaluate each patient thoroughly before surgery (**Boxes 5** and **6**).
- Develop a coordinated treatment plan, including a timeline for tapering postoperative opioids.
- Communicate the treatment plan and planned taper with the patient, and, with the patient's consent, the family and primary care provider.
- Follow through with the agreed-upon postoperative plan to taper off opioids.

BOX 8. PROMOTING THE SAFETY OF PATIENTS WITH CONCERNING PRESCRIPTION HISTORIES[2,55]

If your patient has recently filled multiple prescriptions written by different providers and/or filled at different pharmacies:

- Emphasize your concern for the patient, providing an opportunity for the patient to disclose a problem.
- Explain the risk for fatal overdose at high dosages and when opioids are used with other central nervous system depressants, including benzodiazepines.
- Consider whether the patient meets criteria for a substance use disorder (**Box 3**).
- Avoid abruptly discontinuing opioids, because this can cause significant physical distress. Moreover, the patient may miss an important opportunity to begin effective treatment or may seek other opioids, including heroin (see page 23 for tapering guidance).
- Communicate and coordinate with your patient's other controlled substance providers after obtaining patient consent.

FOR CHRONIC NONCANCER PAIN

Outside of end-of-life care, nonopioid approaches to chronic pain management are preferred because they are typically safer. Long-term opioid use has not been found to produce better pain or functional outcomes than nonopioid approaches. Prescribe opioids extremely judiciously for chronic noncancer pain[63] and, in addition to universal precautions, take the following steps to promote optimum care and patient safety.[22,34,37,64]

Offer naloxone

Offer naloxone (**Box 10**[65-68]) to patients on chronic opioid therapy (≥3 months).

Plan regular face-to-face visits with patients

Conduct regular (at least monthly) in-office visits and document communications to thoroughly assess ongoing risks and benefits of opioid therapy.

Set and discuss realistic goals for treatment

- Set realistic goals such as reducing (rather than eliminating) pain and increasing function.
- Frame opioid therapy as a trial or test of care to support the patient's progress toward the goals of treatment. This approach allows the patient to understand why or when modification in therapy may be warranted.
- Discuss potential risks of opioid therapy (**Boxes 1-3** and **9**).
- Include appropriate nonpharmacologic and nonopioid adjuvant therapies in the treatment plan to improve functional capacity, relieve pain, and help the patient manage the condition.
- Coordinate care with the patient's other providers whenever possible, with the patient's permission.

Establish a patient-provider agreement

Have a signed patient-provider opioid treatment agreement, written at a level that patients can easily understand, to document the purpose of the proposed treatment plan, the health care team's responsibilities toward the patient, the risks and benefits of opioid treatment, expectations for behaviors that mitigate risk, and criteria for changing or discontinuing treatment.[69] Review the agreement with the patient periodically (**Resources**).

MONITOR FOR EFFICACY, ADHERENCE, AND ADVERSE EVENTS

Use face-to-face visits to monitor all patients for pain relief, functional improvement, and adverse effects, and identify whether changes in regimen are needed.

Use face-to-face visits to evaluate the **Six A's**:

1. Analgesia[37,64]
2. Activities (ensure that the patient is making progress toward pain relief and functional activity goals)[37,64]
3. Adverse effects[37,64]
4. Aberrant medication-taking behavior (eg, unsanctioned dose escalation, resistance to change therapy despite adverse effects such as oversedation)[37,64]
5. Affect (eg, depression, anxiety)[64]
6. Adherence

Perform urine drug testing

Urine drug testing (UDT) can provide objective evidence to confirm that patients are using their prescribed medications and identify use of other medications or drugs that could be dangerous to their health.[35,70] UDT is one of several clinical tools used to guide patients' pain management; it should not function as a punitive measure. Perform UDT at baseline and periodically thereafter.

UDT has important limitations; labs and point-of-care drug testing kits vary as to their sensitivity, potentially

BOX 10. PREVENTING FATAL OPIOID OVERDOSE WITH NALOXONE[65-68]

- Naloxone safely reverses opioid overdose and can be given to an overdosing person by trained friends and family members.
- Naloxone presents no potential for misuse and has not been shown to increase risky drug use.
- Offer naloxone to patients with these risk factors:
  - Chronic opioid therapy (≥3 months)
  - High-dose opioid prescription (≥90 MME/day)
  - Prescribed concurrent opioids and benzodiazepines
  - Opioid misuse/illicit use (including past or current history, current treatment for opioid use disorder, or opioid overdose history)
  - Decreased tolerance after a period of abstinence (eg, incarceration, hospitalization, detoxification)
  - Family/friend of someone who meets criteria.

See Naloxone for Overdose Prevention Prescribing Guidelines for Clinical Settings.

BOX 9. WHAT TO TELL PATIENTS ABOUT OPIOID THERAPY[34,51,56,57]

Clearly communicate with patients about the risks of opioid therapy and state the goals of pain management. Explain that opioids are short-term treatment for a specific condition and that you will reevaluate if pain has not resolved at scheduled follow-up.

Risks

- Prescribed opioid analgesics have many of the same risks as heroin.
- Your body may come to depend on the opioids (physical dependence), and stopping them may make you crave them or feel sick.
- Your body may come to need more opioids to get the same effect on your pain (tolerance).
- Sometimes people who take opioid analgesics can lose control over their use. This increases the risk for even more serious consequences such as addiction or fatal overdose.
- An overdose can cause a person to stop breathing and may lead to death.
- Opioids can cause side effects such as
  - slow reaction time, which increases the risk of accidents,
  - slowed breathing,
  - nausea, vomiting, constipation, and dry mouth,
  - drowsiness and confusion: you feel sleepy and can't do much besides take your medication, or you forget all or part of what happens when you were taking it,
  - increased sensitivity to pain,
  - sexual dysfunction.

Patient instructions

- Take the opioids exactly as prescribed, and never take more than prescribed.
- Avoid mixing opioid analgesics with any drugs, particularly alcohol, benzodiazepines (eg, Valium®, Xanax®), or other sedating prescribed or nonprescribed drugs. This can increase the risk of overdose and death.
- Don't buy or share opioids that are not prescribed to you.
- Never buy opioids from people who are not licensed pharmacists or from stores (including online) that are not authorized to sell them. These retailers may sell illicitly manufactured opioids that contain a lethal combination of high-risk opioids (eg, fentanyl, carfentanil).
- Never take more than prescribed.
- Avoid drinking alcohol if you're taking opioids.
- Keep your opioids in their original labeled containers and store them out of sight and reach of children, preferably in a locked location.
- Dispose of opioids you are no longer using. Flush unused opioids down the toilet, or mix with cat litter or coffee grounds and throw in the trash. See FDA guidelines.

Let me or another health care provider know if

- you have a craving (very strong urge to take opioids),
- you think a lot about getting and taking opioids, to the point of neglecting your family, work, friends, or school,
- you feel sick when you stop taking opioids.

If someone has taken opioids and has become very drowsy, is confused, breathing slowly or snoring, or can't wake up, call 911 right away and then administer naloxone.

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leading to false negatives or positives.[70] Misinterpretation of UDT results is common; consult with a toxicologist or clinical pathologist to help interpret UDT and determine the need for appropriate confirmatory testing.[35]

ADDRESS SUSPECTED OPIOID MISUSE AND OPIOID USE DISORDER

If you suspect misuse or OUD based on patient behaviors or UDT, discuss your concern with your patient and provide an opportunity for the patient to disclose related concerns or problems.

If signs of misuse

- Emphasize your concern for the patient's safety and well-being.
- Discuss reasons for misuse, including uncontrolled pain symptoms, and consider changing the treatment plan.
- Use the treatment agreement to discuss concerns and reasons to continue or taper opioids.

If signs of OUD

Eight percent to 12% of patients on chronic opioid analgesic therapy may develop an OUD.[20] If you suspect your patient meets DSM-5 diagnostic criteria for OUD (**Box 3**):

- Communicate your concern for your patient's safety and well-being.
- Avoid abruptly discontinuing opioids, because this can cause significant physical distress.
- Offer to arrange for patients to receive evidence-based treatment, usually opioid agonist therapy with buprenorphine or methadone in combination with behavioral therapies (**Resources for Patients**).

If a patient misuses opioids but does not meet the criteria for OUD, offer to taper or discontinue opioids, as appropriate. For patients who elect to but are unable to taper or discontinue opioids, reassess for OUD and offer opioid agonist therapy if criteria are met.

BUPRENORPHINE OR METHADONE FOR OPIOID USE DISORDER

Buprenorphine and methadone are effective treatments for OUD and achieve better long-term health and social outcomes than treatment without these medications.[71,72]

Buprenorphine can be prescribed in the general practice setting after providers obtain a federal waiver; methadone treatment is only available in specialized treatment settings. See Buprenorphine—An Office-Based Treatment for Opioid Use Disorder.

- Consider consultation with an addiction specialist, if needed, for help assessing or treating patients for OUD.
- Consider becoming a buprenorphine prescriber. See Treating Opioid Use Disorder for details.
- Other medications for OUD have emerging evidence, including long-acting injectable naltrexone and injectable buprenorphine.

DISCONTINUING OPIOID THERAPY

Discontinuation of opioid therapy is necessary in cases of diversion, resolution of the source of the pain, or lack of efficacy.[73,74] Patients who have developed a physical dependence are at risk for opioid withdrawal syndrome if opioid therapy is abruptly discontinued. If there is no physical dependence, then tapering is not needed.

Opioid tapering is indicated when the patient

- requests dosage reduction,
- experiences overdose or other serious adverse event,
- shows early warning signs of overdose risk such as confusion, sedation, or slurred speech.

Consider tapering or reducing dosage when the patient

- is taking high dosages (eg, ≥90 MME/day),
- is co-prescribed benzodiazepines,
- shows signs of misuse or OUD,
- does not have clinically meaningful improvement in pain and function.

How to taper[51,73]

A dose reduction of 10% per week may be reasonable for most patients, but the reduction depends on the patient's risks, such as a previous nonfatal overdose. Patients who have taken opioids for a long time may require a slower taper (eg, 10% per month).

- Explain to the patient that you are reducing or stopping a dangerous treatment, not abandoning him or her. Emphasize your concern for your patient's safety and well-being.
- Coordinate with specialist and treatment experts as needed.
- Offer and arrange appropriate psychosocial support as needed, including counseling, medication assisted-treatment for OUD, and naloxone for overdose prevention.
- Let patients know they may have improved function without worse pain after tapering opioids, and may even have less pain.

ONGOING PAIN MANAGEMENT

For patients with unresolved pain, timely referral to pain specialists may not always be possible. Consider seeking education in managing pain and forming relationships with pain specialists who can help when needed.

SUMMARY

Prevent opioid misuse, OUD, overdose, and death by prescribing opioids judiciously. Use universal precautions to promote efficacy and safety for all of your patients and ensure that patients understand the risks of opioid analgesics. ◆

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OPIOIDS QUIZ

1. Which of the following is true about prescribing opioids?
   A. You should screen all patients for unhealthy substance use and mental health conditions before initiating opioid therapy.
   B. Outside of end-of-life care, nonopioid approaches to chronic pain management are typically safer.
   C. In New York State, providers can prescribe no more than a 7-day supply of opioids for initial treatment of acute pain.
   D. All of the above.

2. Which of the following is true about monitoring patients who are taking opioids?
   A. Buprenorphine and methadone are not effective treatments for opioid use disorder.
   B. You should use face-to-face visits to monitor patients taking opioids.
   C. Naloxone should never be offered to patients taking opioids.
   D. If your patient has opioid use disorder, you should discontinue opioids immediately.

Answers: 1–**D**; 2–**B**.

RESOURCES FOR PROVIDERS

New York City Health Department

- Opioid prescribing (educational resources, OpioidCalc app): www1.nyc.gov/site/doh/providers/health-topics/opioid-prescribing.page
- Overdose Prevention Resources for Providers: www1.nyc.gov/site/doh/providers/health-topics/overdose-prevention-resources-for-providers.page
- Opioid use disorder treatment: www1.nyc.gov/site/doh/providers/health-topics/treating-opioid-addiction.page www1.nyc.gov/site/doh/health/health-topics/opioid-treatment-medication.page

Pain and functional assessment and monitoring tools

- Three-Item Pain, Enjoyment and General Activity (PEG): www.med.umich.edu/1info/FHP/practiceguides/pain/PEG.Scale.12.2016.pdf
- Brief Pain Inventory: static.medicine.iupui.edu/divisions/rheu/content/physicians/bpisf.pdf
- Roland Morris Disability Questionnaire: www.rmdq.org
- Pain Management Resource Directory (includes assessment tools): www.compassionandsupport.org/index.php/for_professionals/pain_management

Mental health and substance use assessment tools

- AUDIT Alcohol Consumption Questions: www.ewashtenaw.org/government/departments/wcho/ch_auditc.pdf
- CRAFFT Adolescent Substance Abuse Screening Tool: www.ceasar-boston.org/CRAFFT/screenCRAFFT.php
- PHQ-2 or PHQ-9 for depression assessment: www1.nyc.gov/assets/doh/downloads/pdf/chi/chi-35-1.pdf
- Generalized Anxiety Disorder Screener (GAD-2 or GAD-7): www.hiv.uw.edu/page/mental-health-screening/gad-2 www.hiv.uw.edu/page/mental-health-screening/gad-7
- DAST-10: www.bu.edu/bniart/files/2012/04/DAST-10_Institute.pdf
- SQS: www.ncbi.nlm.nih.gov/pmc/articles/PMC2911954/

Pain treatment agreement

- Sample Patient-Provider Opioid Treatment Agreement (Rhode Island): health.ri.gov/forms/agreements/SamplePrescriberPatientAgreementOpioidTreatmentForNonCancerPain.doc

Opioid prescribing guidance

- CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016: www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
- SCOPE of Pain: Safe and Competent Opioid Prescribing Education, Boston University School of Medicine: www.scopeofpain.com/folio/activity.pdf

Opioid tapering

- CDC Pocket Guide: Tapering Opioids for Chronic Pain: www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

Opioid overdose prevention

- NYC Health Department Overdose Prevention Resources for Providers (guidance and training video on prescribing naloxone in clinical setting): www1.nyc.gov/site/doh/providers/health-topics/overdose-prevention-resources-for-providers.page
- Naloxone and Overdose Prevention in Pharmacies (includes list of pharmacies and patient handout): www1.nyc.gov/site/doh/providers/health-topics/naloxone-and-overdose-prevention-in-pharmacies.page
- NYS Department of Health Opioid Overdose Prevention Program: www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/

Buprenorphine certification

- Substance Abuse and Mental Health Services Administration. Buprenorphine: www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine
- Providers Clinical Support System for Medication Assisted Treatment: pcssmat.org/

Drug disposal

- US Food and Drug Administration. Disposal of Unused Medications: What You Should Know: www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186187.htm
- NYS Department of Health Bureau of Narcotic Enforcement: 866-811-7957; www.health.ny.gov/professionals/narcotic

City Health Information Archives (www1.nyc.gov/site/doh/providers/resources/city-health-information-chi.page)

- Addressing Alcohol and Drug Use—An Integral Part of Primary Care
- Buprenorphine—An Office-based Treatment for Opioid Dependence
- Judicious Prescribing of Benzodiazepines
- Detecting and Treating Depression in Adults
- Clinical Guidelines for Adults Exposed to the World Trade Center Disaster **(includes GAD-7)**

RESOURCES FOR PATIENTS

- NYC Well provides a confidential connection in more than 200 languages to crisis counselors and mental health referral services:
  - Text WELL to 65173
  - Chat: nycwell.cityofnewyork.us/en/
  - Phone: 888-NYC-WELL (888-692-9355)
- NYC Health Department. Opioid Addiction Treatment with Buprenorphine and Methadone: www1.nyc.gov/site/doh/health/health-topics/opioid-treatment-medication.page
- Substance Abuse and Mental Health Services Administration
  - Behavioral Health Treatment Services Locator: findtreatment.samhsa.gov/
  - Buprenorphine Treatment Practitioner Locator: www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator
- NYS Office of Alcoholism and Substance Abuse Services. OASAS Provider and Program Search: www.oasas.ny.gov/providerDirectory/index.cfm?search_type=2

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