

West Virginia: Diversion of Drugs, 1 unit

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Contact hours: 1

Course price: \$19

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This course meets the 1-unit requirement for coursework in drug diversion mandated by West Virginia Senate Bill 437. It is for any licensee who participates in prescribing, dispensing, or administering controlled substances.

Course Summary

The problem of drug diversion: evidence-based information about and the safeguards to prevent diversion, misuse, abuse, addiction, and overdose deaths.

COI Support

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Criteria for Successful Completions

80% or higher on the post test, a completed evaluation form, and payment where required. No partial credit will be awarded.

Course Objectives

When you finish this course you will be able to:

1. Describe the five Schedules of medications under the Controlled Substances Act.
2. Compare and contrast acute and chronic pain and discuss the trends in treatment of chronic pain.

3. Identify the demographic of drug abusers in U.S. society and cite five groups from whom they may get drugs.
4. List eleven risk factors for substance abuse nurses and other health professionals experience specific to their workplace environments.
5. Name at least four tools for monitoring ongoing opioid therapy.
6. Describe Prescription Drug Monitoring Programs (PDMPs) and explain drug take-back programs.
7. Name four FDA-approved medications to treat opioid use disorder.

Abuse of Controlled Substances

The misuse and abuse of drugs is a crisis in our country and around the world. By 2020 mental health and substance abuse disorders will surpass all physical diseases as a major cause of disability worldwide. Abuse of prescription drugs / drug diversion is the largest drug problem in the United States, and one that is growing. According to the United States Centers for Disease Control and Prevention (CDC), people from all age groups, ethnic backgrounds, and genders are affected by this disease.

The 2016 National Survey on Drug Use and Health (NSDUH) indicates 28.6 million people aged 12 or older used an illicit drug in the past 30 days, which corresponds to about 1 in 10 Americans overall (10.6%) and an estimated 11.8 million people misused opioids in the past year, including 11.5 million pain relief misusers and 948,000 heroin users.

Additional information was gathered in NSDUH for the misuse of pain relievers in 2017. Among people aged 12 or older who misused pain relievers in the past year, about 6 out of 10 people indicated that the main reason they misused the last time was to relieve physical pain (62.3%), and about half (53.0%) indicated that they obtained the last pain relievers they misused from a friend or relative (SAMHSA, 2017b).

Accidental overdose and misuse of prescription drugs leads to the severe consequences of death and addiction. In 2016, there were more than 63,600 drug overdose deaths in the United States. The age-adjusted rate of drug overdose deaths in 2016 (19.8 per 100,000) was 21% higher than the rate in 2015 (16.3) (Hedegaard et al., 2017). *The New York Times* recently reported that opioids are now the leading cause of death of Americans under the age of 50 (Katz, 2017).

Defining the Problem

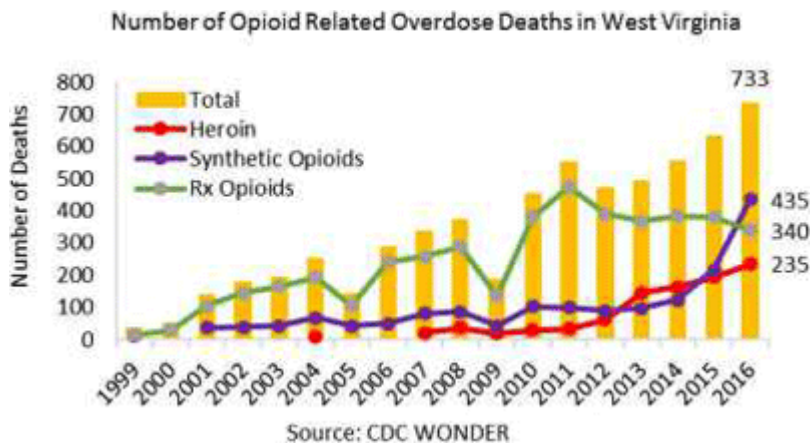
Health professionals face a dilemma because their patients often *need* prescription drugs but they also face a need to prevent the diversion and misuse of drugs. Among the prescription drugs diverted and misused are pain relievers, tranquilizers, stimulants, and sedatives. Opioid analgesics are powerful painkillers medically indicated in the treatment of chronic pain; however, when the patient takes the wrong dose, or the wrong person takes the opioid pain medication, the consequences can be deadly.

While the sales of opioid analgesics increased 4-fold between 1999 and 2010, the United States concurrently experienced an almost 4-fold increase in opioid overdose deaths (SAMHSA/NSDUH, 2014). Other consequences of the abundance of opioids include emergency department visits and admissions, falls and fractures in older adults, and initiating injection drug use, which increases risk for infections such as hepatitis C and HIV.

West Virginia's SB437 is a response to the state's need for additional education about drug diversion and abuse mitigation. The following are some statistics for West Virginia:

- In 2016, West Virginia had the highest rate of opioid-related overdose deaths in the United States—a rate of 52.0 deaths per 100,000 population, which is up from 1.8 deaths per 100,000 in 1999.
- The peak number of overdose deaths was 733 in 2016. The majority of these deaths were from synthetic opioids and heroin.
- Since 2010 deaths related to synthetic opioids quadrupled from 102 to 435 and deaths related to heroin rose from 28 to 235.
- In 2013 West Virginia providers wrote 110 opioid prescriptions per 100 persons (2.8 million prescriptions). The average U.S. rate for opioid prescriptions was 70 per 100 persons in the same year (NIDA, 2018).
- West Virginia Department of Health and Human Resources (DHHR) county-level Neonatal Abstinence Syndrome (NAS)* data for 2017 shows the overall incidence rate of NAS was 50.6 cases per 1,000 live births (5.06%) for West Virginia residents (WV DHHR, 2018).

* **Neonatal Abstinence Syndrome (NAS)** is a withdrawal syndrome that occurs after prenatal exposure to drugs is discontinued suddenly at birth.



What is the role of clinicians in the problem of prescription drug diversion, misuse, and abuse? Clinicians are in a unique position to educate, identify, and intervene with patients and colleagues who are at risk for prescription drug misuse and abuse. Recognizing the signs of misuse and risk factors of drug abuse and diversion by patients and fellow healthcare professionals is an important responsibility of all clinicians. Educated health professionals can be instrumental in changing patterns of misuse and abuse of prescription drugs for individuals, colleagues, and communities, and thereby reducing the public health epidemic.

Glossary of Terms

Aberrant drug-related behaviors: any medication-related behaviors that depart from strict adherence to the physician-prescribed plan of care, ranging from mildly problematic behavior (such as hoarding medications) to illegal acts (such as selling medications).

Addiction: a primary, chronic, neurobiologic disease whose development and manifestation is influenced by genetic, psychosocial, and environmental factors. Addiction behaviors often include impaired control over use, compulsive use, continued use despite resulting harm, and craving (Corsini & Zacharoff, 2014). Like other chronic diseases, addiction often involves cycles of relapse and remission. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DMS-5) does not use the term *addiction* for diagnosis (SAMHSA, 2018).

Abuse/nonmedical use: Abuse is the use of an illicit drug or the intentional self-administration of a prescription (or over-the counter) medication for any nonmedical purpose, such as altering one's state of consciousness, eg, "getting high." However, some critics dislike the term *abuse* being applied to substance use disorders and claim it is inaccurate and reflects morality-based language to depict what may actually be a medical condition (Corsini & Zacharoff, 2014).

Chronic pain: any pain that lasts several months (variously defined as 3 to 6 months), but may last for months or years. Whereas acute pain is a normal sensation that alerts the body to injury or damage, chronic pain persists. Chronic pain may result from an injury or an ongoing cause such as illness, or there may be no clear cause (NIH, 2018).

Diversion: the intentional removal of a medication from legitimate distribution and dispensing channels. Diversion also involves the sharing or purchasing of prescription medication between family members and friends or individual theft from family and friends (Corsini & Zacharoff, 2014). Diversion can also occur in healthcare settings if health professionals divert medication from the intended recipient.

Opioid use disorder (OUD): per the DSM-5, a disorder characterized by loss of control of opioid use, risky opioid use, impaired social functioning, tolerance, and withdrawal. Tolerance and withdrawal do not count toward the diagnosis in people experiencing these symptoms when using opioids under appropriate medical supervision. OUD covers a range of severity and replaces what DSM-IV termed "opioid abuse" and "opioid dependence." An OUD diagnosis is applicable to a person who uses opioids and experiences at least 2 of the 11 symptoms in a 12-month period (SAMHSA, 2018).

Misuse: any therapeutic use of a medication other than as directed or indicated, whether intentional or unintentional, and regardless of whether it results in harm. Increasing a medication dose without prescriber approval is misuse, whether the reason is dependence, tolerance, desire to achieve greater therapeutic effect, or forgetfulness (Corsini & Zacharoff, 2014).

Physical dependence: a state in which the body has adapted to a drug or class of drugs to the degree that withdrawal syndrome occurs upon abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist (Corsini & Zacharoff, 2014).

Controlled Substances

Drug abuse is not a new problem. The United States Congress passed the first Controlled Substances Act in 1970, but addictive drugs were first outlawed in America in the early 1900s. The Controlled Substances Act presents schedules numbered I, II, III, IV, and V.

Controlled Substances, 2018

DEA schedule	Medical use/abuse potential
Schedule I	No accepted therapeutic use. Lack of safety even under medical supervision. High potential for abuse; abuse may lead to severe psychological or physical dependence
Schedule II	Accepted therapeutic use. Highly restricted. High potential for abuse; abuse may lead to severe psychological or physical dependence
Schedule III	Accepted therapeutic use. Highly restricted. Less high potential for abuse; abuse may lead to moderate or low physical dependence or high psychological dependence.
Schedule IV	Accepted therapeutic use. Low potential for abuse relative to Schedule I, II, and III drugs; abuse may lead to limited physical dependence or psychological dependence.
Schedule V	Accepted therapeutic use. Low potential for abuse relative to Schedule I, II, III, and IV drugs; abuse may lead to limited physical dependence or psychological dependence.

Source: DEA, 2018.

On August 22, 2014, the U.S. Drug Enforcement Agency (DEA) formally rescheduled hydrocodone combination products (HCPs), moving them from Schedule III to Schedule II of the Controlled Substances Act.

The Treatment of Pain

Acute and Chronic Pain

Acute Pain is a normal physiologic sensation that signals injury or disease. It serves a vital function, warning of the need for medical treatment.

Chronic pain is pain that persists, often for weeks, months, or years. The presence of chronic pain is a disease state in itself. When the pain's warning function is completed, continued pain is an abnormal state. Its distinct pathology causes changes in the nervous system that often worsen. Its effects on a patient's psychology and cognitive ability are significant, and include anxiety, depression, and anger.

The National Institutes of Health, National Center for Complementary and Integrative Health (NCCIH), reports the following statistics about chronic pain in the United States:

- About 25.3 million U.S. adults (11.2%) had pain every day for the previous 3 months.
- Nearly 40 million adults (17.6%) had severe pain.
- Individuals with severe pain had worse health, used more healthcare, and had more disability than those with less severe pain.
- The annual economic cost of chronic pain in the United States, including both treatment and lost productivity, has been estimated at nearly \$635 billion. (NIH, 2018a)

Trends in Pain Management and Prescribing

In past decades, concern about undertreatment of pain led to increases in prescribing of analgesics. In 1998 the Federation of State Medical Boards (FSMB) released guidelines that supported the use of opioids for chronic, noncancer pain. This contributed to the increase in opioid prescriptions that followed. The Joint Commission, an accrediting body, then issued the **Pain Standard**, which evaluated healthcare organizations (including hospitals, ambulatory care centers, behavioral health, and home care) on the basis of their consistent, documented assessment of patients' pain (Zimmerman, 2017).

Balance is the goal in treating patients' pain and preventing drug diversion. On January 1, 2018, the Joint Commission implemented a new and revised pain assessment and management standards. The new standards, which revise the original standards established in 2001, state that hospitals must:

- Establish a clinical leadership team
- Actively engage medical staff and hospital leadership in improving pain assessment and management, including strategies to decrease opioid use and minimize risks associated with opioid use
- Provide at least one non-pharmacologic pain treatment modality
- Facilitate access to prescription drug monitoring programs
- Improve pain assessment by concentrating more on how pain is affecting patients' physical function
- Engage patients in treatment decisions about their pain management
- Address patient education and engagement, including storage and disposal of opioids to prevent these medications from being stolen or misused by others

- Facilitate referral of patients addicted to opioids to treatment programs. (The Joint Commission, 2018)

NCCIH is part of the National Institutes of Health Pain Consortium, which coordinates pain research across NIH. NCCIH-supported studies are helping to build an evidence base on the effectiveness and safety of complementary modalities for treating chronic pain. The scientific evidence suggests that some of the complementary health approaches that may help people manage chronic pain include mindfulness-based interventions, hypnosis, and cannabinoids (NIH, 2018).

. . . The amount of opioids being prescribed by our nation's doctors, dentists and nurses is excessive. While opioids offer relief to many patients with pain and should remain an available and acceptable option for pain management when medically indicated, it is clear from prescribing data and related addiction treatment admission and overdose death data that the medical community has over-relied on opioids to treat pain. (ASAM, 2017)

Prescription Drug Abuse and Misuse

Because of changes in pain treatment, prescriptions of opioid analgesics have increased dramatically from the 1990s. This increase resulted in their increased availability for nonmedical users (NIDA, 2018).

The U.S. culture of drug use, faith in pharmaceutical solutions, and desire for rapid relief from pain has contributed to the increase in opioid prescriptions. Alcohol use plays a role in drug abuse. Manufacturers of pharmaceuticals market directly to consumers in all types of media. This, combined with information about medications that is widely available on the Internet, leads to patients' asking doctors for drugs by name.

The increase of prescription opioids has exacted a severe toll. Unintentional overdose deaths have quadrupled since 1999, and now far outnumber those from heroin and cocaine combined. The CDC considers prescription drug abuse to be epidemic. According to the CDC, approximately 116 Americans died from opioid-related causes every day in 2016.

The drugs involved in overdose deaths in the United States have changed in recent years. The rate of drug overdose deaths involving synthetic opioids other than methadone (drugs such as fentanyl, fentanyl analogs, and tramadol) doubled in a single year from 3.1 per 100,000 in 2015 to 6.2 in 2016. Overdose deaths involving heroin increased from 4.1 in 2015 to 4.9 in 2016. Overdose deaths involving natural and semisynthetic opioids (morphine, codeine, hydrocodone, and oxycodone) increased from 3.9 in 2015 to 4.4 in 2016 (Hedegaard et al., 2017).

In response to this crisis, the federal government has taken steps to inform more judicious opioid prescribing through the development of the CDC's Guideline for Prescribing Opioids for Chronic Pain. Current data shows that the rates of prescribing are decreasing. Between 2006 and 2016, the annual prescribing rate per 100 persons decreased from 72.4 to 66.5 for all opioids, which is an overall 8.1% reduction (CDC, 2017a).

Societal and Economic Impacts of Drug Abuse

Drug use affects not only the drug abuser but also the family unit and the community at large. Overdose and accidental death impacts family members and caregivers as well as our healthcare system. Drug abuse impacts on-the-job performance and missed work. A study published in 2016 found the total economic burden of the opioid crisis in the United States is estimated to be \$78.5 billion. More than one-third of this amount is due to increased healthcare and substance abuse treatment costs (\$28.9 billion) (Florence et al., 2016).

A U.S. Council of Economic Advisers (CEA) report estimates that in 2015 the economic cost of the national opioid crisis was \$504.0 billion, or 2.8% of GDP that year. This is more than 6 times larger than the most recently estimated economic cost of the epidemic (CEA, 2017).

The 2018 National Institute on Drug Abuse (NIDA) report on opioids in West Virginia reveals some societal costs of drug abuse in the state. Other health consequences include increases in cases of hepatitis C (HCV) and HIV. In 2015 West Virginia reported 6,347 cases of chronic HCV and 63 cases of acute HCV, or rates of 344.2 cases of chronic HCV per 100,000 population and 3.4 cases of acute HCV per 100,000. Among acute cases, nearly 40% were attributed to intravenous drug use. Of the 39,513 new cases of HIV in 2015 in the United States, 74 occurred in West Virginia (NIDA, 2018).

What Drugs Are Most Diverted or Abused?

After marijuana, prescription drugs are the second-most abused category of drugs in the United States (SAMHSA, 2017b). The three classes of the most commonly abused prescription drugs are:

- Opioids that include oxycodone (Percocet, Tylox, OxyContin), hydrocodone (Vicodin, Lortab), and methadone (Dolophine);
- Central nervous system depressants (sedatives) that include butalbital (Fiorinal/Fioricet), diazepam (Valium), and alprazolam (Xanax);
- Stimulants that include methylphenidate (Ritalin) and amphetamine/dextroamphetamine (Adderall). (SAMHSA, 2017b; NIDA, 2018)

One way to understand the scope of the problem of illegal and prescription drug misuse and abuse is to look at data on drug-related emergency department (ED) visits. The 2017 Annual Surveillance Report of Drug-Related Risks and Outcomes reports an estimated 259,665 hospitalizations for nonfatal, unintentional drug poisoning occurred in 2014. Opioid poisoning accounted for 20.4% (53,000) of these hospitalizations. Heroin was specified as the involved opioid for 21.7% (11,475) of opioid hospitalizations (CDC, 2017a).

An estimated 418,313 ED visits for nonfatal, unintentional drug poisoning occurred in 2014. Opioids accounted for 22.1% (92,262) of these ED visits. Heroin was specified as the involved opioid for 58.5% (53,930) of opioid ED visits. Cocaine accounted for 6,424 and methamphetamines for 11,012 visits (CDC, 2017a).

Who Are the Drug Abusers?

People of all ages, genders, and backgrounds use illicit or prescription drugs nonmedically.

- During 2015 an estimated 2,038,000 persons in the United States aged 12 years or older had a substance use disorder involving prescription pain relievers, with an estimated rate of 0.8 per 100 persons (CDC, 2017a).
- During 2015 an estimated 47,730,000 persons in the United States aged 12 years or older used illicit drugs or misused prescription drugs in the past year, with an estimated rate of 17.8 per 100 persons. Among males, the estimated rate was 20.5; among females, it was 15.3. By race and ethnicity, the estimated rates were 20.7 for non-Hispanic blacks, 17.9 for non-Hispanic whites, and 17.2 for Hispanics (CDC, 2017a).
- During 2016, an estimated 3.3 million people aged 12 or older were current misusers of prescription pain relievers (SAMSHA, 2017b).
- In 2016 an estimated 239,000 adolescents aged 12 to 17 were current misusers of pain relievers, which corresponds to 1.0% of adolescents. An estimated 631,000 young adults aged 18 to 25 misused pain relievers in the past month, which represents 1.8% of young adults. For comparison, in 2013, the rate of past year nonmedical pain reliever use among youth aged 12 to 17 was 4.6. For young adults ages 18 to 25, the rate was 8.8%.
- In 2016, 11.5 million people aged 12 or older misused prescription pain relievers in the past year compared with 948,000 people who used heroin. The majority of prescription pain reliever misusers had misused only prescription pain relievers in the past year but had not used heroin (10.9 million). Approximately 641,000 people had

misused prescription pain relievers and also used heroin in the past year (SAMSHA, 2017b).

- Overall, more males than females misuse prescription drugs in all age groups except adolescence (12 to 17 years); adolescent girls exceed boys in the nonmedical use of all prescription drugs, including pain relievers, sedatives, and stimulants. Among nonmedical users of prescription drugs, females 12 to 17 years old are also more likely to meet substance use disorder criteria for prescription drugs. Additionally, while more men than women die of prescription opioid overdose, the rate of overdose is increasing more sharply in women than in men (NIDA, 2018).

How Drug Abusers Get Drugs

Drug diversion is any intentional removal of a prescription medication from the legitimate channels of distribution and dispensing.

Friends and Family

Although we might assume that drug users acquire their prescription drugs from street dealers, this is not usually the case. Because prescription medications are fairly commonly prescribed, often nonmedical users merely have to look in the medicine cabinet of a family member or friend.

In 2015, among persons aged 12 and older who had misused prescription pain relievers in the past 12 months, the following sources were reported for the most recent misuse:

- 40.5% reported they obtained drugs free of charge from a relative or friend.
- 36.4% reported they obtained drugs through a healthcare provider via prescription or by stealing.
- 34% reported they obtained drugs from one doctor.
- 9.4% reported they bought or stole drugs from a relative or friend.
- Only 1.7% reported getting drugs from more than 1 doctor.
- Only 4.9% reported buying drugs from a dealer or stranger.

Strikingly, these data suggest that drug dealers are a relatively small source of illicitly used prescription opioids. Diversion through family and friends is now the greatest source of illicit opioids (Dixon, 2018).

Doctor Shopping

Another source for prescription drugs is legitimate prescriptions obtained illicitly. Patients may request prescriptions from more than one physician, and thereby receive more than one prescription for pharmaceuticals. This is known as "doctor shopping." The patient does not inform the physicians of the multiple prescribers and fills multiple prescriptions for the same or similar medication at different pharmacies. Recent data shows, however, the majority of opioids are obtained by prescription from one physician, not from "doctor shopping" (Dixon, 2018).

Fraud

Patients seeking to feed a habit of drug misuse or abuse may attempt to pass fraudulent prescriptions at the pharmacy. Fraudulent prescriptions come in the following forms:

- Fraudulent prescriptions written for a fictitious patient on a legitimate prescription pad stolen from a prescriber's office
- Legitimate prescription that has been altered to obtain additional amounts of a drug
- Legitimate prescription pad with an altered call-back phone number to verify the prescription
- Fraudulent prescription called in by the drug abuser, who gives his or her own call-back number
- Fraudulent prescription created by a computer for a fictitious doctor or copied from a legitimate doctor

Healthcare Professionals

[Material in this section is from NCSBN, 2011 and 2014, unless otherwise identified.]

Drug diversion isn't only a problem in patients, however. Pharmacists, physicians, nurses, and other health professionals often have access to prescription drugs. These individuals are subject to the same propensities, temptations, genetic and medical histories, and physical and mental health problems as patients.

Prescribers may be involved in drug diversion by providing drugs to patients engaging in the practices of fraud or doctor shopping, who may be selling or sharing drugs.

Health professionals may also divert drugs for their own use. Nurses and other healthcare professionals have about the same prevalence of substance abuse and addiction as the general public. But, there are unique workplace factors that actually increase a nurse's opportunity and risk for addiction. The behavior that results from addiction has far-reaching negative effects, not only on clinicians themselves but also upon the patients who depend on the nurse for safe, competent care.

Substance use disorder can affect nurses regardless of age, occupation, economic circumstances, ethnic background, or gender. The earlier substance use disorder in a nurse is identified and treatment is started, the sooner patients are protected and the better the chances are of the nurse returning to work.

Clinicians must be trained to recognizing substance misuse and abuse among fellow health professionals because substance abuse on the job and untreated substance use disorder jeopardizes patient safety and creates significant legal and ethical responsibilities for colleagues who work with these individuals.

General symptoms of substance use problems among nurses include the following:

- Defensiveness
- Isolation
- Irritability
- Difficulty following through on work assignments

Signs and symptoms of a prescription drug substance use disorder among nurses can include the following:

- Coming to work on days off
- Volunteering for overtime
- Incorrect narcotic counts
- Volunteering to administer medications
- Waiting to be alone to open a narcotics cabinet
- Lacking witnesses to verify the wasting of unused medications
- Absences from the unit for extended periods
- Frequent trips to the bathroom,
- Arriving late or leaving early and an
- Excessive number of mistakes including medication errors

Negative impacts on patient safety may result from any of the following:

- Impaired judgment
- Slowed reaction time
- Diverting drugs from patients who need them
- Neglect of patients

- Nursing errors

Nurse managers and colleagues should also watch for subtle changes in appearance over time as well as behavioral changes, such as wearing long sleeves in warm weather, increasing isolation from colleagues, inappropriate verbal or emotional response, or diminished alertness, confusion, or memory lapses.

Many nurses with substance use disorder are unidentified, unreported, untreated, and may continue to practice where their impairment may endanger the lives of their patients.

NCSBN, 2014

Addiction and substance abuse have been called an occupational hazard for all health professionals. In addition to general risk factors to which all members of the population are subject (eg, depression, anxiety, stress, low self-esteem, use of other substances, early age of first misuse, alcohol and drug use by peers, family use, genetic predisposition to alcohol or drug dependence), nurses face specific risk factors in their workplace environments:

- Role strain, including burnout, work overload, feeling of insignificance, and inadequate support at work
- Problems of daily living, such as loss of a significant other, poor coping skills, insecurity, and isolation
- Enabling by peers and managers, such as overlooking symptoms out of loyalty and fear of job loss
- Attitudes toward drugs and drug use; eg, that substance use is an acceptable means of coping with life
- Faith in drugs for promoting healing due to witnessing positive effects of drugs on patients
- Sense of entitlement, that the nurse must continue to work, leading to rationalization
- Special status of nurses as invulnerable to illnesses of patients
- Professional training about drugs leading to self-diagnosis and self-medication for pain or stress/fatigue from workplace demands
- Lack of education regarding substance use disorder, including lack of understanding about the addiction process and how to recognize signs and symptoms of abuse
- Lack of controls and security of controlled substances and their ready availability

- Physician prescribing practices, such as obtaining prescriptions from physician friends without proper assessment and diagnosis protocols

Of these risk factors, the top four are access to drugs, attitude, stress, and lack of education about addiction. The National Council of State Boards of Nursing (NCSBN) had made the NCSBN courses “Understanding Substance Use Disorder in Nursing” and “Nurse Manager Guidelines for Substance Use Disorder” free of charge for all nurses and nursing students (<https://www.ncsbn.org/>).

A Clinical Approach to Mitigate Abuse

The use of prescription drugs including opioid analgesics for other-than-legitimate medical purposes poses a significant health risk to individual patients and to society. Inappropriate prescribing can lead to drug diversion and abuse by individuals seeking to use opioids nonmedically. It falls to clinicians to use systematic precautions to minimize the possibility for abuse and diversion of controlled substances.

Risk Factors for Opioid Abuse and Drug Diversion

Research shows that there are several categories of risk factors for opioid abuse and addiction:

- Genetic predisposition
- Certain brain characteristics that can make someone more vulnerable to addictive substances than the average person
- Psychological factors (eg, stress, personality traits like high impulsivity or sensation seeking, depression, anxiety, eating disorders, personality and other psychiatric disorders)
- Environmental influences (eg, exposure to physical, sexual, or emotional abuse or trauma; substance use or addiction in the family or among peers; access to an addictive substance; exposure to popular culture references that encourage substance use)
- Starting alcohol, nicotine, or other drug use at an early age (CASA, 2017)

One factor that is strongly predictive of opioid abuse, misuse, or other aberrant drug-related behavior is a personal or family history of alcohol or drug abuse. However, the FDA (2014) wants clinicians to recognize that

. . . a history of substance abuse does not prohibit treatment with extended release/long-acting opioid analgesics but may require additional monitoring and expert consultation (FDA, 2014).

Assessment

SAMHSA's Opioid Overdose Prevention Toolkit recommends that a thorough patient assessment and health history include specific questions. For example:

- "In the past 6 months, have you taken any medications to help you calm down, keep from getting nervous or upset, raise your spirits, make you feel better, and the like?"
- "Have you been taking any medications to help you sleep? Have you been using alcohol for this purpose?"
- "Have you ever taken a medication to help you with a drug or alcohol problem?"
- "Have you ever taken a medication for a nervous stomach?"
- "Have you taken a medication to give you more energy or to cut down on your appetite?"
- "Have you ever been treated for a possible or suspected opioid overdose?"

Further, a patient history should include questions about the patient's use of alcohol and over-the-counter medicines (SAMHSA, 2016a).

Physical Examination

During a physical examination, clinicians should also be on the lookout for the following signs in patients being seen for chronic pain:

- Needle marks in neck, hands, feet, and antecubital fossae
- Signs of opioid intoxication, including pinpoint pupils, sweating, drowsiness, nodding off, slurred speech, respiratory depression, stupor, and coma
- Signs of opioid withdrawal, including goose bumps, sweating, diarrhea, sniffles, dilated pupils, lacrimation, muscle tenderness, increased bowel sounds, shivering, nausea, emesis, rapid heartbeat, restlessness, and hypertension
- Signs of liver disease, including jaundice, enlarged liver and spleen, "stigmata" of chronic liver disease, and ascites (Dixon, 2018)

Periodic Review and Monitoring of Patients

Any treatment for pain should periodically be reviewed and evaluated by the clinician. New information about the patient's state of health, condition or cause of pain, psychosocial and mental health, and nature of pain is noted. The clinician should look at the patient's dosage, the medication schedule (to determine if the patient is indeed taking the prescription as directed) and whether the current treatment should be continued or modified. This decision depends on evaluation of the progress toward the treatment objectives previously outlined in the plan of care. At such a review, it is critical to reinforce correct medication usage.

Guidelines for Prescribing Opioids

- 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.
- 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.
- 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.
- Clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
- Before starting (and periodically during continuation of opioid therapy), clinicians should evaluate risk factors for opioid-related harms. They should incorporate into the management plan strategies to mitigate risk, including considering the offer of naloxone in the presence of 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. (CDC, 2017b)

"Because organized medicine basically caused this problem, it's really going to take organized medicine to reverse it," said Gary Franklin, University of Washington (Solis, 2014).

Monitoring Treatment

Regular monitoring and ongoing assessment is essential to determine if the treatment plan is on track and the patient is achieving results. Clinicians should incorporate the following practices in their patient monitoring:

- Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
- Clinicians should prescribe the lowest effective dosage. They 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.
- 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. 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.
- 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.
- Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible. 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. (CDC, 2017b)
- 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.
- Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. They 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.

Identifying Diversion and Drug-Seeking Behaviors

The purpose of risk assessment is to determine the likelihood that a patient will develop or display aberrant drug-related behaviors. Healthcare providers must be observant at all times for signs of nonadherence to treatment plans and dosage instructions. Aberrant drug-related behaviors include the following:

- Escalating the dose without a clinician's order, especially rapidly escalating the dose. Psychoactive tolerance develops quickly, forcing a drug abuser to take more of the medication to achieve the same effect, often in doses significantly higher than a therapeutic dose for pain. In contrast, analgesic tolerance develops slowly. It would be expected that patients with stable pain would stay on the same dose for months or years.
- Taking the drug in larger doses than prescribed and running out of medication early. Patients abusing opioids may aggressively request refills earlier than expected, or request additional doctor visits.
- Acquiring opioids from sources other than by order of the clinician, such as an emergency department, acquiring additional doctors, or buy purchasing the drug on the street.
- Altering or acquiring prescriptions by means of theft, fraud, or purchase.
- Using the drug in any method other than that which was prescribed, such as by snorting, injecting, or chewing oral medications for quicker effect. (NIDA, n.d.)

Spectrum of Aberrant Drug-Taking Behaviors

Steven Passick created this list in 2009 but it remains useful today.

More suggestive of addiction*

- Concurrent abuse of alcohol or illicit drugs
- Evidence of deterioration in the ability to function at work, in the family, or socially that appears to be related to drug use
- Injecting oral formulations
- Multiple dose escalations or other nonadherence with therapy despite warnings
- Obtaining prescription drugs from nonmedical sources
- Prescription forgery
- Repeated resistance to changes in therapy despite clear evidence of drug-related diverse physical or psychological effects
- Repeatedly seeking prescriptions from other clinicians or emergency departments without informing prescriber
- Selling prescription drugs
- Stealing or borrowing drugs from others

*Documented in patient's medical chart.

Less suggestive of addiction

- Aggressive complaining about the need for more drugs
- Drug hoarding during periods of reduced symptoms
- Openly acquiring similar drugs from other medical sources
- Requesting specific drugs
- Reporting psychic effects not intended by the clinician
- Resistance to a change in therapy associated with tolerable adverse effects accompanied by expressions of anxiety related to the return of severe symptoms
- Unapproved use of the drug to treat another symptom
- Unsanctioned dose escalation or other nonadherence with therapy on 1 or 2 occasions.

Source: Passik, 2009.

As is evident above, not all aberrant drug-related behaviors by patients signify addiction. They may instead signify that the patient:

- Is experiencing increased pain
- Has accidentally been misusing the medication by taking more than intended
- Is developing a physical tolerance to the opioid analgesic, which is not as effective as it once was
- Is rationing doses to save money, for example, or selling doses for income
- May have someone in his or her household or living situation who is stealing medication from the patient (Corsini & Zacharoff, 2014)

Clinicians should look closely to determine the reason for the unexpected or aberrant behaviors. Such behaviors are important clinical signs.

It is important to consider all behaviors, and the multitude of reasons that patients may not take their medications as they are prescribed. Understanding the specific reason for each unexpected behavior can help the clinician to take the correct next step, and make decisions that help minimize risk, improve safety, and most of all benefit the patient (Corsini & Zacharoff, 2014).

General Symptoms of Narcotic Abuse

Healthcare professionals must be on the lookout for the following signs and symptoms of opioid use disorder:

- Analgesia (feeling no pain)
- Sedation
- Euphoria (feeling high)
- Respiratory depression (shallow or slow breathing)
- Small pupils
- Nausea, vomiting
- Itching or flushed skin
- Constipation
- Slurred speech
- Confusion or poor judgment

Tools for Monitoring Ongoing Opioid Therapy

Prescribers have a number of tools at their disposal to help with ongoing assessment of chronic pain patients who are receiving opioid analgesic therapy. Here are a few of those tools.

Addiction Behaviors Checklist (ABC)

Developed by Bruce D. Naliboff with support from VA Health Services Research and Development, this is a 20-item, yes/no assessment tool that can increase a provider's confidence in determinations of appropriate vs. inappropriate opioid use (Wu et al., 2006).

Chabal 5-Point Prescription Opiate Abuse Checklist

This is a five-point questionnaire that assesses the risk of opioid abuse through evaluation of behaviors that are consistent with opioid abuse rather than answers to specific questions (Chabal et al., 1997).

Pain Medication Questionnaire (PMQ)

This is a 26-item self-report assessment tool for ongoing monitoring of aberrant behaviors. It helps clinicians to identify whether a long-term chronic pain patient is exhibiting aberrant behaviors associated with opioid medication misuse (Dowling et al., 2007).

Prescription Drug Use Questionnaire (PDUQ)

The PDUQ assesses problematic opioid misuse, abuse, and dependence in chronic pain patients. Evidence suggests the PDUQ's key screening indicators are excellent predictors for the presence of addiction (Compton et al., 2008).

Drug Abuse Screening Test (DAST)

A self-administered questionnaire consisting of 28 items with binary (yes/no) answers created by Harvey A. Skinner in 1982. Scores of 6 or more indicate the presence of substance dependence or abuse with satisfactory measures of reliability and high levels of validity, sensitivity, and specificity (Yudko et al., 1997). A shorter 10-question DAST (DAST-10) also is used.

Current Opioid Misuse Measure (COMM)

A 17-item patient self-assessment that helps clinicians identify whether a patient, currently on long-term opioid therapy, may be exhibiting aberrant behaviors associated with misuse of opioid medications. Since the COMM examines concurrent misuse (2007), it is ideal for helping clinicians monitor patients' aberrant medication-related behaviors over the course of treatment (Butler et al., 2007).

Urine Screens

Regular urine drug screening (UDS) is appropriate for patients who are at higher risk for opioid abuse or addiction, and for any patient who is exhibiting signs of misuse or aberrant drug behavior. Urine screening can indicate drug diversion, misuse, or abuse, and the presence of an illegal drug might indicate addiction. Any nonprescribed opioid may signal drug abuse or doctor shopping.

Pill Counting

Pill counting is one method of ensuring medication adherence and helps to prevent drug diversion. Counting pills is done to compare the number of doses remaining in a prescription container with the number of doses that should remain, if the patient adhered to the medication schedule perfectly. However, a clinician cannot be sure that absent pills were consumed; they may have been diverted instead. Healthcare professionals must keep careful records about the amount of medication dispensed, prescription date, date the prescription was filled, and how many doses remain before the refill.

Prescription Drug Monitoring Programs (PDMPs)

Clinicians should request a report of a patient's medication history from the state's PDMP before prescribing controlled substances. PDMPs track controlled substances prescribed by authorized practitioners and dispensed by pharmacies. PDMPs assist in patient care, provide early-warning signs of drug epidemics, and help to detecting drug diversion and insurance fraud.

West Virginia's Prescription Drug Monitoring Program, the Controlled Substance Automated Prescription Program (CSAPP), was established in 1995 by the State Board of Pharmacy for the monitoring of Schedule II–IV Controlled Substances. The goal of CSAPP is to provide prescribers and dispensers with access to information that will help them make better prescribing decisions and positively impact West Virginia's drug problem. Furthermore, CSAPP can help to identify patients who may benefit from a substance abuse referral (CSAPP, 2018).

When Drug Diversion Is Suspected

If a healthcare professional suspects that drug diversion has occurred, he or she must document the suspicion and make a report to the following agencies:

Local law enforcement and local fraud alert networks

- DEA (theft or loss of controlled substances) on the DEA Office of Diversion Control website: <https://www.deadiversion.usdoj.gov/webforms/dtlLogin.jsp>
- HHS-OIG National Hotline (800 HHS-TIPS, or 800 447 8477) or TTY 800 377 4950 or at this website: <https://forms.oig.hhs.gov/hotlineoperations/index.aspx>

Other resources for information and assistance are listed at the end of this course.

Drug Take-Back Programs

Combating prescription drug abuse necessitates the proper disposal of unused, unneeded, or expired medications. Patients must have a secure and convenient way to dispose of controlled substances. The Drug Enforcement Agency has strict regulations for drug take-back programs, including National Prescription Drug Take Back Days. Healthcare providers should encourage patients to use such take-back disposal services when available.

The 14th National Take Back Day, which took place October 28, 2017, collected 912,305 pounds (456 tons) of prescription drugs nationwide. In West Virginia 5,473 pounds of prescription drugs were collected (DEA, 2018).

Key Concepts in Treating Opioid Addiction

Addiction is a chronic, treatable illness. Treating patients with **opioid use disorder (OUD)** requires continuing care rather than an episodic, acute-care approach. Patients should have access to medical treatment, mental health services, addiction counseling, and other recovery support services. Treatment should be tailored to each patient's needs and preferences (ASAM, 2015). In fact, there is no single best approach that works for all patients. A comprehensive approach to treatment is part of addressing the problem of drug diversion. Research shows that many people in need of treatment for substance use disorder do not receive treatment.

- The 2015 National Survey on Drug Use and Health (NSDUH) data indicate that 8.1% or 21.7 million people aged 12 or older needed substance use treatment in the past year.
- In 2015 an estimated 2.3 million people aged 12 or older who needed substance use treatment received treatment at a specialty facility in the past year. This number represents 10.8% of the 21.7 million people who needed substance use treatment in the past year (SAMHSA, 2016b).

Medications

The FDA has approved medications to treat OUD and improve patients' health and wellness. These medications are methadone, naltrexone, and buprenorphine. These medications can reduce or eliminate withdrawal symptoms (methadone, buprenorphine), blunt or block the effects of illicit opioids (methadone, naltrexone, buprenorphine), and reduce or eliminate craving to use opioids (methadone, naltrexone, buprenorphine). People with OUD can benefit from medications for varying lengths of time, including lifetime treatment. Further, studies show that medication as part of treatment of OUD is cost-effective.

Did You Know . . .

Treatment with OUD medication is linked to better outcomes and retention than treatment without medications.

Healthcare providers need special training and certification to prescribe medications to treat OUD. A patient taking FDA-approved medication for OUD can be considered to be in recovery. Clinicians should also be aware that diversion of medications for treating OUD do occur (ASAM, 2015).

Preventing Opioid Overdose–Related Deaths

Opioid overdose–related deaths can be prevented when naloxone is administered in a timely manner. As a narcotic antagonist, naloxone displaces opiates from receptor sites in the brain and reverses respiratory depression that usually is the cause of overdose deaths.

Resources and References

Resources

Substance Abuse and Mental Health Services Administration (**SAMHSA**) National Helpline:
1-800-662-HELP (4357) or
1-800-487-4889 (TDD—for hearing impaired)

Behavioral Health Treatment Locator

(search by address, city, or zip code)

<https://findtreatment.samhsa.gov>

Buprenorphine Treatment Physician Locator

<http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator>

Centers for Disease Control and Prevention (CDC)

<http://www.cdc.gov/drugoverdose/epidemic>

<http://www.cdc.gov/homeandrecreationalafety/poisoning>

References

American Society of Addiction Medicine (**ASAM**). (2015). National Practice Guideline in the Use of Medications for the Treatment of Addiction Involving Opioid Use. Retrieved April 8, 2018 from <https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf>.

American Society of Addiction Medicine (**ASAM**). (2012). Public policy statement on measures to counteract prescription drug diversion, misuse, and addiction. Retrieved April 20, 2018 from <http://www.asam.org>.

American Society of Addiction Medicine (**ASAM**). (2017). June 16, 2017 Letter to Chris Christie, Chair, President's Commission on Combating Drug Addiction and the Opioid Crisis. Retrieved 4/20/18 from <https://www.asam.org/docs/default-source/advocacy/letters-and-comments/asam-recommendations-6-16-17.pdf?sfvrsn=2#search=%22trends%20in%20pain%20management%22>.

Butler SF, Budman SH, Fanciullo GJ, et al. (2007). Cross Validation of the Current Opioid Misuse Measure (COMM) to Monitor Chronic Pain Patients on Opioid Therapy. Retrieved July 5, 2018 from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2955853/>.

Centers for Disease Control and Prevention (**CDC**). (2017a). Annual Surveillance Report of Drug-Related Risks and Outcomes—United States, 2017. Surveillance Special Report 1. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Published August 31, 2017. Retrieved April 14, 2018 from <https://www.cdc.gov/drugoverdose/pdf/pubs/2017-cdc-drug-surveillance-report.pdf>.

Centers for Disease Control and Prevention (**CDC**). (2017b). Guideline for Prescribing Opioids for Chronic Pain. Fact Sheet. Retrieved 4/15/2018 from https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf.

Chabal C, Erjavec MK, Jacobson L, et al. (1997). Prescription Opiate Abuse in Chronic Pain Patients: Clinical Criteria, Incidence, and Predictors. Retrieved July 5 2018 from https://journals.lww.com/clinicalpain/Abstract/1997/06000/Prescription_Opiate_Abuse_in_Chronic_Pain.9.aspx.

Compton P, Darakjian J, Miotto K. (2008, October). Introduction of a Self-report Version of the Prescription Drug Use Questionnaire and Relationship to Medication Agreement Non-Compliance. *J Pain Symptom Manage*. 36(4): 383–95.

Controlled Substance Automated Prescription Program (**CSAPP**). (2018). West Virginia Board of Pharmacy. Retrieved April 8, 2018 from <https://www.csappwv.com/Account/Login.aspx?ReturnUrl=%2f>.

Corsini E, Zacharoff KL. (2014, 2011). Definitions related to aberrant drug-related behavior: Is there correct terminology? Retrieved 4/20/2018 from <https://www.painedu.org/definitions-aberrant-drug-related-behavior/>.

Council on Economic Advisers (**CEA**). (2017). The Underestimated Cost of the Opioid Crisis. Retrieved 4/15/2018 from

<https://www.whitehouse.gov/sites/whitehouse.gov/files/images/The%20Underestimated%20Cost%20of%20the%20Opioid%20Crisis.pdf>.

Dixon DW. (2018). Opioid Abuse: Practice Essentials, Background, Pathophysiology Retrieved 4/15/2018 from <https://emedicine.medscape.com/article/287790-overview#showall>.

Dowling LS, Gatchel RJ, Adams LL. (2007). An evaluation of the predictive validity of the Pain Medication Questionnaire with a heterogeneous group of patients with chronic pain. Retrieved July 5, 2018 from <https://www.ncbi.nlm.nih.gov/pubmed/18181380>.

Drug Enforcement Administration (**DEA**), Diversion and Control Division. (2018). Controlled substances. Retrieved July 5, 2018 from <https://www.deadiversion.usdoj.gov/schedules/>.

Food and Drug Administration (**FDA**). (2014). Opioid Patient-Prescriber Agreement. Retrieved 4/20/2018 from

<https://www.fda.gov/Drugs/DrugSafety/SafeUseInitiative/ucm188762.htm#opioidppa>.

Florence CS, Zhou C, Luo, F, Xu L. (2016, October). The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013. *Medical Care* 10:901–906. Retrieved

4/14/2018 from https://journals.lww.com/lww-medicalcare/Abstract/2016/10000/The_Economic_Burden_of_Prescription_Opioid.2.aspx.

Hedegaard H, Warner M, Miniño AM. (2017). Drug Overdose Deaths in the United States 1999–2016. NCHS Data Brief, No. 294. Hyattsville, MD: National Center for Health Statistics. Retrieved 4/14/2018 from <https://www.cdc.gov/nchs/products/databriefs/db294.htm>.

Joint Commission, The. (2018). Facts about Joint Commission Accreditation Standards for Health Care Organizations: Pain Assessment and Management. Retrieved 4/7/2018 from https://www.jointcommission.org/facts_about_joint_commission_accreditation_standards_for_health_care_organizations_pain_assessment_and_management/.

Katz J. (2017, January 5). Drug Deaths in America Are Rising Faster than Ever. *The New York Times*. Retrieved 4/14/2018 from <https://www.nytimes.com/interactive/2017/06/05/upshot/opioid-epidemic-drug-overdose-deaths-are-rising-faster-than-ever.html>.

National Center on Addiction and Substance Abuse (**CASA**). 2017. Who Develops Addiction? Retrieved 4/8/2018 from <https://www.centeronaddiction.org/addiction/addiction-risk-factors>.

National Council of State Boards of Nursing (**NCSBN**). (2011). Substance Use Disorder in Nursing: A Resource Manual and Guidelines for Alternative and Disciplinary Monitoring Programs. Retrieved April 18, 2018 from https://www.ncsbn.org/SUDN_11.pdf. [Still a valid source. No update made yet.]

National Council of State Boards of Nursing (**NCSBN**). (2014). What You Need to Know About Substance Use Disorder in Nursing. Retrieved April 7, 2018 from https://www.ncsbn.org/SUD_Brochure_2014.pdf.

National Institute on Drug Abuse (**NIDA**). (2018). Misuse of Prescription Drugs. Retrieved 4/20/18 from <https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/2609-misuse-of-prescription-drugs.pdf>.

National Institute on Drug Abuse (NIDA). (2018). Opioid Summaries by State: West Virginia. Retrieved April 14, 2018 from <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/west-virginia-opioid-summary>.

National Institute on Drug Abuse (**NIDA**). (n.d.). Aberrant Drug Taking Behaviors Information Sheet. Retrieved 4/15/2018 from <https://www.drugabuse.gov/sites/default/files/files/AberrantDrugTakingBehaviors.pdf>.

National Institutes of Health (**NIH**). (2018). Chronic Pain In Depth. National Center for Complementary and Integrative Health. NCCIH Pub No.: D456. Retrieved 4/13/2018 from <https://nccih.nih.gov/health/pain/chronic.htm>.

Passik SD. (2009, July). Issues in long-term opioid therapy: Unmet needs, risks, and solutions. *Mayo Clin Proc.* 84(7):593–601. Retrieved July 5, 2018 from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2704131/>.

Solis M. (2014, October 9). Long-Term Opioid Therapy for Chronic Pain: More Harm Than Good? Appreciation of risks brings new guidelines and an initiative to research non-drug alternatives for pain. Retrieved 4/20/2018 from <https://www.painresearchforum.org/news/46387-long-term-opioid-therapy-chronic-pain-more-harm-good>.

Substance Abuse and Mental Health Services Administration (**SAMHSA**). 2018. TIP 63: Medications for Opioid Use Disorder: For Healthcare and Addiction Professionals, Policymakers, Patients, and Families. SMA18-5063FULLDOC. Retrieved 4/14/2018 from <https://store.samhsa.gov/shin/content//SMA18-5063FULLDOC/SMA18-5063FULLDOC.pdf>.

Substance Abuse and Mental Health Services Administration (**SAMHSA**). 2017a. Behavioral Health Barometer: West Virginia, Volume 4: Indicators as measured through the 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System. HHS Publication No. SMA-17-Baro-16-States-WV. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017.

Substance Abuse and Mental Health Services Administration (**SAMHSA**). 2017b. Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved 4/8/2018 from <https://www.samhsa.gov/data/>.

Substance Abuse and Mental Health Services Administration (**SAMHSA**). (2016a). Opioid Overdose Prevention Toolkit: Facts for Community Members, Five Essential Steps for First Responders, Information for Prescribers, Safety Advice for Patients & Family Members, Recovering From Opioid Overdose. HHS Publication No. (SMA) 16-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved 4/13/2018 from <https://store.samhsa.gov/shin/content//SMA16-4742/SMA16-4742.pdf>.

Substance Abuse and Mental Health Services Administration (**SAMHSA**). 2016b. The CBHSQ Report. September 29, 2016. Rachel N. Lipari, Ph.D, Eunice Park-Lee, Ph.D., and Struther Van Horn, M.A. America's Need for and Receipt of Substance Use Treatment in 2015. Retrieved 4/20/2018 from https://www.samhsa.gov/data/sites/default/files/report_2716/ShortReport-2716.html.

Substance Abuse and Mental Health Services Administration (**SAMHSA**), National Survey of Drug Use and Health (**NSDUH**). (2014). Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD. Retrieved 4/20/2018 from <http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf>.

U.S. Department of Justice (DOJ), Drug Enforcement Administration (**DEA**). (2018a). Controlled Substances Schedules. Retrieved 4/20/2018 from <https://www.deadiversion.usdoj.gov/schedules/>.

U.S. Department of Justice, Drug Enforcement Administration (**DEA**). (2018b). October 2017 14th National Drug Take Back Day Collection Results. Retrieved 4/7/2018 from https://www.deadiversion.usdoj.gov/drug_disposal/takeback/.

U.S. Attorney's Office, Southern District of West Virginia. (2014, September). Goodwin Encourages West Virginians to Participate in Upcoming Prescription Drug Take-Back Event. Retrieved April 20, 2018 from http://www.justice.gov/usao/wvs/press_releases/September2014/attachments/0925141_DrugTakeBack.html.

West Virginia Department of Health and Human Resources (**WV DHHR**). (2018, April 11). DHHR Researches Neonatal Abstinence Syndrome Data for 2017. Retrieved 4/20/2018 from <https://dhhr.wv.gov/News/2018/Pages/DHHR-Releases-Neonatal-Abstinence-Syndrome-Data-for-2017-.aspx>.

Wu SM, Compton P, Bolus R, et al. (2006). The addiction behaviors checklist: Validation of a new clinician-based measure of inappropriate opioid use in chronic pain. *J Pain Symptom Manage*. 32(4):342-51. Retrieved 4/20/2018 from http://www.emergingsolutionsinpain.com/images/pdf/reslib/Addiction_Behaviors_Checklist.pdf.

Yudko E, Lozhkina O, Fouts A. (1997, March). A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *J Subst Abuse Treat*. 32(2):189-98. Retrieved 4/20/2018 from <http://www.ncbi.nlm.nih.gov/pubmed/17306727>.

Zimmerman, Brian. February 28, (2017, February 28). Becker's Hospital Review. 7 Things to Know About the History of The Joint Commission Pain Standards. Retrieved 4/20/2018 from <https://www.beckershospitalreview.com/opioids/7-things-to-know-about-the-history-of-the-joint-commission-pain-standards.html>.

Post Test

Use the answer sheet following the test to record your answers.

1. The biggest drug problem in the United States is:
 - a. Heroin because it is so cheap.
 - b. Prescription drugs because they are so readily available.
 - c. Crack cocaine because the high is instantaneous.
 - d. Cannabis because it is considered harmless by many.

2. Diversion is:
 - a. Removal of a medication from its legitimate dispensing channels.
 - b. Taking prescribed drugs while distracted.
 - c. Failing to read the directions on a prescribed medication.
 - d. Using a parcel delivery service to move drugs across national boundaries.

3. The Controlled Substances Act has five Schedules designated with roman numerals. The least safe and most likely to be abused is Schedule V:
 - a. True
 - b. False

4. Pain is a normal physiologic sensation that signals injury or disease. Chronic pain:
 - a. Is probably neurologic.
 - b. Always requires scheduled medications.
 - c. Generally has psychological origins.
 - d. Is a disease state in itself.

5. The Federation of State Medical Boards (FSMB) issued guidelines to support the use of opioids for chronic noncancer pain in 1998 (rev. 2004, 2014). Based on their findings, The Joint Commission then issued the "Pain Standard" to:
 - a. Guide family physicians in discerning chronic pain.
 - b. Evaluate healthcare organizations in their assessment of patient pain.
 - c. Enforce compliance with the Controlled Substances Act.
 - d. Help law enforcement to understand use of prescription drugs.

6. Which is NOT a contributing factor in the increase in opioid prescribing:
- Desire for rapid pain relief.
 - Faith in pharmaceutical solutions.
 - Direct marketing to consumers by pharmaceuticals manufacturers.
 - The reclassification of opioids as Schedule V controlled substances.
7. A 2018 NIDA report on West Virginia reveals the following societal costs of drug abuse in the state:
- Obesity rates increasing year for year.
 - Individuals failing to get standard vaccinations.
 - People hospitalized with mental health issues.
 - Increases in numbers of cases of hepatitis C and HIV/AIDS.
8. Apart from cannabis, what drugs are most diverted or abused:
- Opioids, stimulants, and steroids.
 - Opioids, CNS depressants, and stimulants.
 - CNS depressants, stimulants, and marijuana.
 - Marijuana, growth stimulating hormones, and steroids.
9. Drug abusers are generally from lower socioeconomic strata of society:
- True
 - False
10. What behavioral signs among nurses may indicate a substance abuse problem:
- Attending seminars on drug safety and administration.
 - Assessing patients' pain frequently.
 - Waiting to be alone to open a narcotics cabinet.
 - Discussing a friend who has a drug problem.
11. All but one of the following is a top risk factor for nurses who may be vulnerable to drug diversion:
- Access to drugs.
 - Exposure to addicts in daily work.
 - Stress.

- d. Lack of education about addiction.
12. Which of the following signs in a patient may be indicative of a drug problem:
- a. Cheerful, open demeanor.
 - b. Career in healthcare.
 - c. Stigmata of chronic liver disease.
 - d. Respiratory distress.
13. Which of the following aberrant drug-taking behaviors is **more** suggestive of addiction:
- a. Injecting oral formulations.
 - b. Requesting specific drugs.
 - c. Drug hoarding during periods of reduced symptoms.
 - d. Reporting psychic effects not intended by the clinician.
14. Tools for monitoring ongoing opiate therapy include all but one of the following:
- a. Current Opioid Misuse Measure (COMM)
 - b. Drug Abuse Screening Test (DAST)
 - c. Prescription Drug Use Questionnaire (PDUQ)
 - d. Physicians' Drug Misuse Measure (PDMM)
15. Which of the following is a limitation of pill counting:
- a. The clinician cannot be sure that absent pills were consumed.
 - b. It is difficult to compare the number of doses remaining with the number that should remain.
 - c. Prescriptions are always written so that no pills remain before the next appointment.
 - d. Patient records rarely contain the prescription amount, date, and the date the prescription was filled.
16. West Virginia's Prescription Drug Monitoring Program is known as:
- a. C-PAP.
 - b. CSAPP.
 - c. PaP.
 - d. WVDMP.

17. Drug take-back programs have been ignored by the citizens of West Virginia:

- a. True
- b. False

18. Treatment with OUD medication is linked to better outcomes and retention than treatment without medications:

- a. True
- b. False

Answer Sheet

WV: Diversion of Drugs, 1 unit

Name (Please print your name): _____

Date: _____

Passing score is 80%

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____

Course Evaluation

Please use this scale for your course evaluation. Items with asterisks * are required.

- 5 = Strongly agree
- 4 = Agree
- 3 = Neutral
- 2 = Disagree
- 1 = Strongly disagree

* Upon completion of the course, I was able to:

a. Describe the five Schedules of medications under the Controlled Substances Act.

5 4 3 2 1

b. Compare and contrast acute and chronic pain and discuss the trends in treatment of chronic pain.

5 4 3 2 1

c. Identify the demographic of drug abusers in U.S. society and cite five groups from whom they may get drugs.

5 4 3 2 1

d. List eleven risk factors for substance abuse nurses and other health professionals experience specific to their workplace environments.

5 4 3 2 1

e. Name at least four tools for monitoring ongoing opioid therapy.

5 4 3 2 1

f. Describe Prescription Drug Monitoring Programs (PDMPs) and explain drug take-back programs.

5 4 3 2 1

g. Name four FDA-approved medications to treat opioid use disorder.

5 4 3 2 1

* The author(s) are knowledgeable about the subject matter.

5 4 3 2 1

* The author(s) cited evidence that supported the material presented.

5 4 3 2 1

* This course contained no discriminatory or prejudicial language.

Yes No

* The course was free of commercial bias and product promotion.

Yes No

* As a result of what you have learned, do you intend to make any changes in your practice?

Yes No

If you answered Yes above, what changes do you intend to make? If you answered No, please explain why.

* Do you intend to return to ATrain for your ongoing CE needs?

- Yes, within the next 30 days.
- Yes, during my next renewal cycle.
- Maybe, not sure.
- No, I only needed this one course.

* Would you recommend ATrain Education to a friend, co-worker, or colleague?

- Yes, definitely.
- Possibly.
- No, not at this time.

* What is your overall satisfaction with this learning activity?

5 4 3 2 1

* Navigating the ATrain Education website was:

- Easy.
- Somewhat easy.
- Not at all easy.

* How long did it take you to complete this course, posttest, and course evaluation?

- 60 minutes (or more) per contact hour
- 50-59 minutes per contact hour
- 40-49 minutes per contact hour
- 30-39 minutes per contact hour
- Less than 30 minutes per contact hour

I heard about ATrain Education from:

- Government or Department of Health website.
- State board or professional association.
- Searching the Internet.
- A friend.
- An advertisement.
- I am a returning customer.
- My employer.
- Other
- Social Media (FB, Twitter, LinkedIn, etc)

Please let us know your age group to help us meet your professional needs.

- 18 to 30
- 31 to 45
- 46+

I completed this course on:

- My own or a friend's computer.
- A computer at work.
- A library computer.
- A tablet.
- A cellphone.
- A paper copy of the course.

Please enter your comments or suggestions here: _____

Registration Form

Please print and answer all of the following questions (* required).

* Name: _____

* Email: _____

* Address: _____

* City: _____ * State: _____ * Zip: _____

* Country: _____

* Phone: _____

* Professional Credentials/Designations:

Your name and credentials/designations will appear on your certificate.

* License Number and State: _____

* Please email my certificate:

Yes No

(If you request an email certificate we will not send a copy of the certificate by US Mail.)

Payment Options

You may pay by credit card or by check.

Fill out this section only if you are **paying by credit card**.

1 contact hours: \$19

Credit card information

* Name: _____

Address (if different from above): _____

* City: _____ * State: _____ * Zip: _____

* Card type:

Visa Master Card American Express Discover

* Card number: _____

* CVS#: _____

* Expiration date: _____