

New Jersey: Abuse of Prescription Drugs, 1 unit

Authors: Sara E. Wilson, BA

Lauren Robertson, BA, MPT

Tracey Long, RN, PhD, APRN

Contact hours: 1.0

Pharmacotherapy hours: 1

Course price: \$10

Course Summary

As a condition of biennial license renewal, all registered professional nurses and all licensed practical nurses in New Jersey must complete one contact hour of continuing education covering abuse of opioids, management and treatment of pain—including responsible prescribing practices—and diversion of controlled substances.

This course offers evidence-based information about the problem of prescription drug abuse and misuse, alternatives to opioids for managing and treating pain, best practices for prescribing controlled substances, and drug diversion and safeguards to prevent diversion.

Learning Objectives

When you finish this course, you will be able to:

1. State 4 factors that have contributed to the opioid crisis.
2. Relate the three classes of most-abused prescription drugs.
3. Describe the difference between tolerance, dependence, and addiction.
4. State the 3 main guidelines NJ providers must follow when prescribing controlled dangerous substances, including opioids in any schedule.
5. List 5 complementary alternatives to opioids for pain management.
6. Relate the 5 most common sources of illicit drugs.

Instructions for Mail Order

Once you've finished studying the course material:

1. Record your test answers on the answer sheet.
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1. Abuse and Misuse of Prescription Drugs

Two decades ago a trend arose in which there was little question about using opioids to treat acute and chronic pain. Although opioid use was mostly well intentioned, individual consequences have been serious: it initiated a dramatic increase in dependence, addiction, and overdose, as well as lesser known side effects such as neonatal abstinence syndrome and transmission of infectious diseases. Society has suffered loss of productivity, increased crime and violence, neglect of children, and expanded healthcare costs.

Prescribing opioids for acute and chronic pain (and diversion of prescription pain medications) has become so widespread that nearly one hundred thirty people per day, or fifty thousand per year, die from opioid overdose. The availability of narcotic-reversal drugs such as Narcan (naloxone) has helped but has not stopped the epidemic of opioid deaths.



Source: CDC.

COVID: A Crisis Within a Crisis

Unfortunately, the COVID pandemic has only made matters worse, causing what some call “a crisis within a crisis.” More than forty states have reported increased opioid deaths since the beginning of the coronavirus pandemic (Desmon, 2020).

The United States, in the twelve months ending in May 2020, experienced the highest number of overdose deaths ever recorded in a 12-month period. While overdose deaths were already increasing in the months preceding the COVID-19 pandemic, the latest numbers suggest an acceleration of overdose deaths during the pandemic (CDC, 2020, December 17).

Data from CDC released at the beginning of 2021 has confirmed this spike in overdose deaths. From June 1919 to June 2020, drug overdose deaths increased by more than 20%. During that time period, New Jersey experienced an increase of almost 9% (NCHS, 2021).

People with a substance use disorder may be more susceptible to COVID due to the many healthcare challenges faced by this population. It may be more difficult to find medical care due to inequities and stigma, and many people have medical and psychiatric comorbid conditions. Lung function may be diminished, especially for those who use methamphetamine, vape, or smoke cigarette or marijuana. A high percentage of individuals with substance use disorder experience homelessness and are exposed to increased transmission of COVID-19 in homeless shelters and prisons (Volkow, 2020).

Contributing Factors

Over the last two decades, several factors have contributed to the opioid crisis:

- Pain was added as the fifth vital sign in 1996, leading to practices that sought to minimize or eliminate pain.
- Campaigns by pharmaceutical companies advertised the effectiveness of their drugs for the treatment of acute and chronic pain.
- Clinical practice guidelines were influenced by pharmaceutical companies and financial and conflict-of-interest disclosures were lacking by some researchers and clinicians. (Spithoff et al., 2020)

Pain as a Fifth Vital Sign

The introduction of pain as the fifth vital sign, by the American Pain Society in 1995, the Veteran's Health Administration in 1999, and by The Joint Commission in 2001, overemphasized pain as a quantifiable measure. The intent was to ensure that pain is measured and treated (Bernard et al., 2018).

Perceptions of undertreatment led to increased use of opioids, at first for cancer-related pain and later for noncancer pain. The increased use was related to exaggerated claims in the medical literature (and by the pharmaceutical industry) of a lack of addiction—claims that were subsequently found to be false and deliberately deceptive (Bernard et al., 2018).

As a result, an epidemic of opioid prescribing began in the 1990s, resulting in an alarming rise in opioid deaths. This has led to efforts to decrease use, both in patients with noncancer conditions as well as those with cancer and the survivors of cancer (Bernard et al., 2018).

The Pharmaceutical Industry

Evidence slowly emerged about the harm associated with the use of opioids for pain management but prescriptions for opioids nevertheless gradually increased, and then exploded. The influence of the pharmaceutical industry has been described a "pervasive" by some researchers (Spithoff et al., 2020).

In one particularly egregious example, in the late 1990s, Purdue Pharma began aggressively marketing Oxycontin (oxycodone) for chronic non-cancer pain through academic detailing* and education sessions for physicians. Other pharmaceutical companies followed suit. These activities have been linked to the rise in opioid prescriptions (Spithoff et al., 2020).

***Academic detailing:** Peer-to-peer educational outreach that has its roots in pharmaceutical detailing and was designed to improve prescribing practices by physicians.

There is evidence that the pharmaceutical industry may have influenced physicians' clinical practice guidelines. Organizations that produced the guidelines failed to regularly employ mechanisms—such as appointing a methodologist in a lead role or conducting an external review—to mitigate potential bias from industry involvement (Spithoff et al., 2020). Purdue also provided financial support to the American Pain Society, the American Academy of Pain Medicine, the Federation of State Medical Boards, The Joint Commission, pain patient groups, and other organizations (Lopez, 2018).

Clinician Disclosures

Some researchers involved with the development of guidelines either did not report—or accurately report—funding sources for the sponsoring organization and conflicts-of-interest for individuals. One top cancer researcher consistently failed to disclose millions in payments, although accurate disclosure was the accepted standard during that time. Reasons that individuals and organizations do not declare conflicts of interest have been poorly studied but may include: not understanding what to declare, believing that a conflict is irrelevant, and worrying about reducing trust in the guideline user (Spithoff et al., 2020).

The year 2020 saw the largest ever settlement by a pharmaceuticals company for its role in fueling the opioid crisis. Purdue Pharma pleaded guilty on November 24 to felony charges that included paying illegal kickbacks to physicians who prescribed unnecessary or excessive doses of the drug. As part of the settlement, Purdue Pharma agreed to pay \$8 billion to the United States, and to dissolve the business and form a public benefit corporation that would continue manufacturing drugs but steer profits from future opioid sales toward programs aimed at alleviating the addiction crisis (Desmon, 2020).

Three Waves

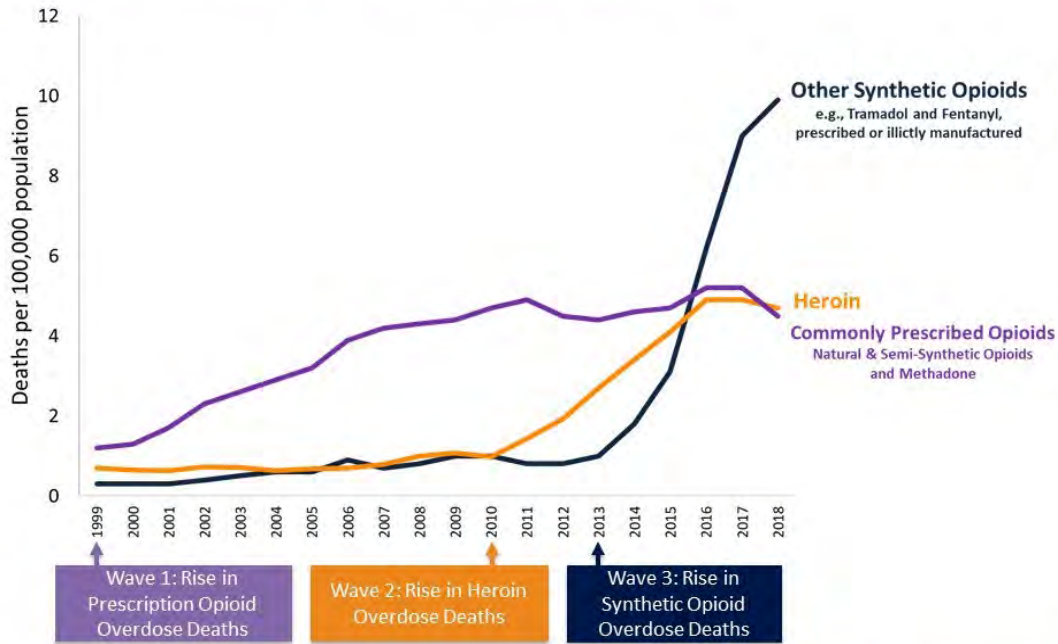
This rise in opioid overdose deaths can be outlined in three distinct waves. The **first wave** began with increased prescribing of opioids in the 1990s, which saw overdose deaths involving prescription opioids (natural and semi-synthetic opioids and methadone) increasing since at least 1999. The **second wave** began in 2010, with rapid increases in overdose deaths involving heroin (CDC, 2020, March 19).



The **third wave** began in 2013, with significant increases in overdose deaths involving synthetic opioids, particularly those containing illicitly manufactured fentanyl. The market for illicit fentanyl continues to change, and it can be found in combination with heroin, counterfeit pills, and cocaine (CDC, 2020, March 19).

Oxycodone tablets. Source: National Library of Medicine.

3 Waves of the Rise in Opioid Overdose Deaths



SOURCE: National Vital Statistics System Mortality File.

Source: CDC, 2020, September 3.

RISE IN OPIOID OVERDOSE DEATHS IN AMERICA

A Multi-Layered Problem in Three Distinct Waves

Nearly 450,000 people died from an opioid overdose (1999-2018)

1990s
mark a rise in prescription opioid overdose deaths

Rx OPIOIDS
Include natural, semi-synthetic, and methadone and can be prescribed by doctors

2010
marks a rise in heroin overdose deaths

HEROIN
An illegal opioid

2013
marks a rise in synthetic opioid overdose deaths

SYNTHETIC OPIOIDS
Include fentanyl and can be illicitly made

Learn more about the evolving opioid overdose crisis: www.cdc.gov/drugoverdose

Illicit **designer drugs** have been particularly difficult to identify and track. Amateur and professional chemists can quickly reproduce a drug, alter its potency, and flood the market with modified compounds undetectable by most known tests. Little is known about the effects of these drugs because their chemical structures are modified so rapidly and so often that it is impossible for researchers and law enforcement to keep up with the changes.

Source: CDC, 2020, September 3.

2. Acceptance of Prescription Opioids

There has been a dramatic increase in the acceptance and use of prescription opioids for the treatment of chronic non-cancer pain, despite serious risks and the lack of evidence about their long-term effectiveness. Although the total number of drug overdose deaths had decreased in the years prior to the COVID-19 pandemic, overdose deaths remain 4 times higher than in 1999 (CDC, 2020, March 19).

Opioid Overdose



Source: National Library of Medicine.

Breaking overdose deaths down by category shows the following:

- Prescription opioids overdose deaths have decreased by 13.5%.
- Heroin overdose deaths have decreased by 4%.
- Synthetic opioids overdose deaths (excluding methadone) increased by 10% in 2018. (CDC, 2020, March 19)

Percent of Opioid Deaths

Nearly 85% of overdose deaths involved illicitly manufactured fentanyl, heroin, cocaine, or methamphetamine (alone or in combination).

Source: CDC, 2020, September 4.

Most-Abused Drugs

The three classes of most-abused prescription drugs are:

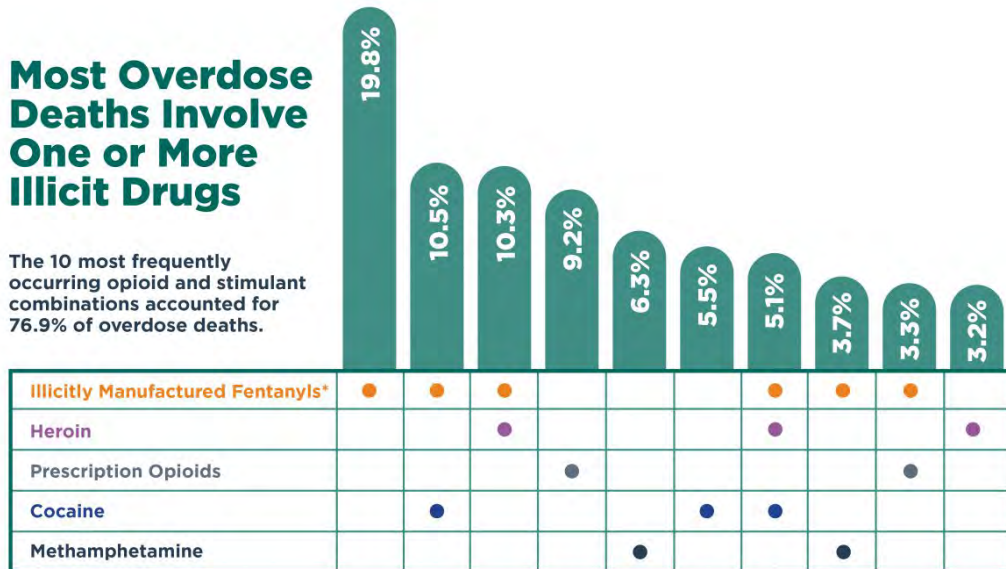
1. Opioids that include oxycodone (Percocet, Tylox, OxyContin), hydrocodone (Vicodin, Lortab), and methadone (Dolophine).
2. Central nervous system depressants that include butalbital (Fiorinal/Fioricet), diazepam (Valium), and alprazolam (Xanax).
3. Stimulants that include methylphenidate (Ritalin) and amphetamine/dextroamphetamine (Adderall). (NIDA, 2020, June)

Most-Abused Prescription Pain Relievers	
Hydrocodone	Morphine
Oxycodone	Oxymorphone
Codeine	Hydromorphone
Tramadol	Fentanyl
Buprenorphine	

Source: SAMHSA, 2020, May.

Some characteristics of areas with higher opioid prescribing:

- Small cities or large towns
- Higher percent of non-Hispanic white residents
- More dentists and primary care physicians
- Higher percentage of unemployed or uninsured
- Greater percentage of diabetes, arthritis or disability (CDC, 2017, July 6)



*IMFs include fentanyl and fentanyl analogs.

Source: CDC, 2020, September 4.

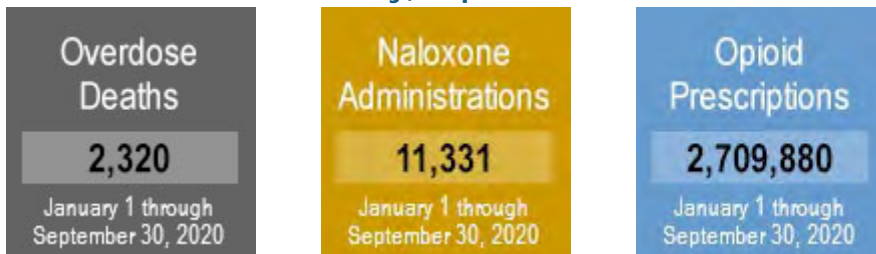
Overdose Deaths in New Jersey

“Eight lives are lost each day to the overdose epidemic in New Jersey,” said Acting Health Commissioner Judith M. Persichilli. “We are committed to linking all those in need to treatment and services by engaging healthcare providers, harm reduction centers, local health officials, and emergency care providers in the fight to save lives.”

NJ Health, 2020

The New Jersey Department of Health has implemented several initiatives to help reverse the tide of the opioid epidemic in the state.

Statistics from New Jersey, September 2020



Source: <https://www.njcares.gov/>

In New Jersey, several programs have been implemented or expanded:

- Expanded the “5 Minutes to Help” training course for Emergency Medical Services staff to improve connections to care for non-fatal overdose victims.
- Increased access to naloxone.
- Working with hospital care providers through the Opioid Reduction Option (ORO) program to decrease opioid prescribing to treat chronic pain in emergency departments.
- Expanding services at Harm Reduction Centers.
- Continuing to improve data collection and analysis through the NJ Overdose Data Dashboard.
- Supporting efforts by behavioral health providers to implement electronic health records and connection to other healthcare providers through the NJ Health Information Network (NJHIN).
- Addressing the overdose epidemic through a health equity lens. (NJ Health, 2020)

3 in 5 People

Potential opportunities to link people to care or to implement life-saving actions were present for more than 3 in 5 people who died from drug overdose.

Source: CDC, 2020, September 4.

3. Tolerance, Dependence, and Addiction

Opioids are a class of drugs that broadly includes heroin, hydrocodone, oxycodone, and other morphine-derived drugs. Brain abnormalities can result from chronic use of such drugs, causing tolerance, dependence, and addiction.

Dependence can resolve after detoxification. Addiction, however, has complex and long-lasting effects, involving craving that can lead to relapse long after the patient's dependence resolves.

Psychological and Analgesic Tolerance

Psychological tolerance develops quickly, meaning a user must take more and 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. Patients with stable pain may be able to stay on the same dose for months or years.

Tolerance often accompanies dependence. When tolerance occurs, it can be difficult to evaluate whether a patient is developing a drug problem or has a medical need for higher doses to control symptoms (NIDA, 2020, June).

Dependence

Dependence is caused by physiologic adaptations due to chronic exposure to a drug. It is often part of addiction, but they are not equivalent. Addiction involves changes to brain circuitry and is distinguished by compulsive drug seeking and use despite negative consequences (NIDA, 2020, June).

Those who are dependent on a medication will experience unpleasant physical withdrawal symptoms when they abruptly reduce or stop use of the drug. These symptoms can be mild to severe, depending on the drug, and can usually be managed medically or avoided by slowly tapering down the drug dosage (NIDA, 2020, June).

Addiction

Addiction is characterized by inability for abstinence, craving, impairment in behavioral control, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death (ASAM, 2015).

Clarifying the difference between dependence and addiction is important to understanding of the issues in opioid use and abuse. Dependence, the physical tolerance of the drug, requires increased amounts of the drug to achieve the desired response. Withdrawal of the drug will result in physical symptoms such as shaking, tremors, nausea, and vomiting. Addiction/substance use disorder is a behavioral disorder that refers to the emotional desire for the drug and the desired effects it brings, which often creates strong drug-seeking behaviors.

Opioid Use Disorder

The DSM-5 defines **opioid use disorder (OUD)** as 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 of OUD in people experiencing these symptoms when using opioids under appropriate medical supervision. Diagnosis of OUD covers a range of severity and replaces what DSM-IV termed “opioid abuse” and “opioid dependence.”

Generally, those who are dependent on opioids vary between feeling sick without the drug and desiring the high that follows after taking the drug. Being addicted to the drug (having OUD) will motivate a person to do whatever it takes to procure and take the drug to avoid the dreaded withdrawal symptoms. Prescription Drug Monitoring Programs (PDPs) are designed to identify patients who are drug-seeking or at risk for opioid use disorder.

4. Responsible Prescribing Practices

In the United States in the previous year about 25 million adults reported pain every day for the previous three months and nearly 40 million adults reported severe pain. Individuals with severe pain have worse health, use more healthcare, and have more disability than those with less severe pain (NCCIH, 2020).


Prescription opioid medications can help treat and manage severe pain but may pose risks for addiction, overdose, and death. These risks are increased when patients are prescribed higher doses of prescription opioids.

Misuse of prescription opioids is a risk factor for heroin use; 80% of people initiating heroin use report prior misuse of prescription opioids (NIDA, 2017). Improving the way opioids are prescribed can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse or overdose from these drugs.

CDC has identified three problem areas:

- Too many prescriptions
- Too many days
- Too high a dose (CDC, 2017, July 6)


Promising actions for safer opioid prescribing.



Problem: High prescribing

Solution: Safer prescribing practices


Problem: Too many prescriptions



In 2015, the amount of opioids prescribed was enough for every American to be medicated **around the clock for 3 weeks.**

(640 MME per person, which equals 5 mg of hydrocodone every 4 hours)

Solution: Fewer prescriptions


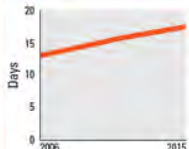


Use opioids **only** when benefits are likely to outweigh risks. Options other than opioids include:

- Pain medicines like acetaminophen, ibuprofen, and naproxen
- Physical therapy and exercise
- Cognitive behavioral therapy

Therapies that don't involve opioids may work better and have fewer risks and side effects.


Problem: Too many days

Even at low doses, taking an opioid for more than 3 months increases the risk of addiction by **15 times.**

Average days supply per prescription increased from 2006 to 2015.


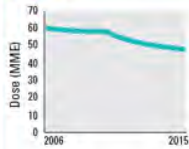
Solution: Fewer days



For acute pain, prescriptions should only be for the expected duration of pain severe enough to need opioids. **Three days or less** is often enough; more than seven days is rarely needed.

If continuing opioids, ask whether benefits continue to outweigh risks. If not, use other treatments and taper opioids gradually.


Problem: Too high a dose

A dose of 50 MME or more per day **doubles** the risk of opioid overdose death, compared to 20 MME or less per day. At 90 MME or more, the risk increases **10 times.**

Average daily MME per prescription declined both nationwide and in most counties, but it is still too high.

Solution: Lower doses



Use the lowest effective dose of immediate-release opioids when starting, and reassess benefits and risks when considering dose increases.

Avoid a daily dose of 90 MME or more. If already taking high doses, offer the opportunity to gradually taper to safer doses.

For more recommendations when considering opioids for chronic pain outside of end-of-life care, see the [CDC Guideline for Prescribing Opioids for Chronic Pain](https://www.cdc.gov/drugoverdose/prescribing/guideline.html). The *Guideline* can also be used to inform health systems, states, and insurers to ensure appropriate prescribing and improve care for all people.

www.cdc.gov/drugoverdose/prescribing/guideline.html

SOURCE: CDC Vital Signs, July 2017

Source: CDC, 2017, July 6.

New Jersey Prescribing Regulations

When prescribing controlled dangerous substances, including opioids in any schedule, providers must:

- Take a thorough history, including any history of substance use disorder;

Then, either

- Conduct a physical exam in-person; or
- During the current COVID-19 public health emergency (PHE), conduct an exam by telemedicine. For prescribing at a first visit, this telemedicine exam must be conducted using real time, interactive, audio-visual methods.
- For subsequent visits, a phone encounter is permitted.
- Develop a treatment plan with identified goals. (New Jersey Consumer Affairs, 2020)

The following requirements also apply, unless the prescription is being issued to a patient being treated for cancer, receiving hospice care, or residing in long term care facility, or the prescription is for treatment of substance use disorder, or if medications are being administered pursuant to medication orders in in-patient facilities:

When issuing an initial prescription for a Schedule II CDS or any opioid for patients suffering from acute pain, the prescriber must:

- Discuss the risks and benefits of opioid treatment and alternatives;
- Limit the prescription to no more than a 5-day supply at the lowest effective dose of an immediate-release formulation;

If, after the initial 5-day prescription, the patient requests a subsequent opioid prescription, the prescriber must:

- Wait until at least the 4th day from the date of the initial prescription;
- Determine, after a consultation, in-person or by telephone, that an additional supply is necessary and does not present a risk of abuse, addiction or diversion;
- Tailor the supply to the patient's need, and never provide more than 30 days.

When prescribing opioids to a patient for chronic pain (pain beyond 3 months), every 3 months the prescriber must:

- Reiterate the discussion of the risks of opioids;
- Enter into a pain management agreement with the patient;
- Reassess treatment goals and make a reasonable periodic effort to taper or stop the prescribing;
- During the current COVID-19 PHE, prescribers must also co-prescribe naloxone if the patient has one or more prescriptions totaling 90 MME or more each day, or is concurrently obtaining an opioid and a benzodiazepine. (New Jersey Consumer Affairs, 2020)

For patients with chronic pain, opioids are associated with small beneficial effects versus placebo but are associated with increased risk of short-term harms and do not appear to be superior to nonopioid therapy. Evidence on intermediate-term and long-term benefits remains limited, and additional evidence confirms an association between opioids and increased risk of serious harms that appears to be dose-dependent. Research is needed to develop accurate risk prediction instruments, determine effective risk mitigation strategies, clarify risks associated with co-prescribed medications, and identify optimal opioid tapering strategies (AHRQ, 2019).

The Dilemma in Acute Pain Management

Acute pain occurs in response to noxious stimuli and is normally sudden in onset and time limited. It usually lasts for less than 7 days but can extend up to 30 days; for some conditions, acute pain episodes may recur periodically. In some patients, acute pain persists to become chronic.

The dilemma in the medical management of acute pain is selecting an intervention that provides adequate pain relief, improves function, and facilitates recovery, while minimizing adverse effects and avoiding overprescribing of opioids. When acute pain is adequately treated, it may prevent the transition to chronic pain (AHRQ, 2020, January 2).

Many factors influence acute pain management. For example, post-operative pain is usually managed with multimodal strategies in a monitored setting prior to discharge. By contrast, treatment of pain in an outpatient setting can be more difficult. A treatment that is effective for one acute pain condition and patient in a particular setting may not be effective in others (AHRQ, 2020, January 2).

Guideline for Chronic Pain

In response to the opioid crisis, in 2016, CDC developed the *Guideline for Prescribing Opioids for Chronic Pain*. The guideline included a recommendation to limit opioids for acute pain in most cases to 3 to 7 days. This recommendation was based on evidence showing an association between use of opioids for acute pain and long-term use. In the last several years, over 25 states have passed laws restricting prescribing of opioids for acute pain (AHRQ, 2020, January 2).

The guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. It addresses (1) when to initiate or continue opioids for chronic pain; (2) opioid selection, dosage, duration, followup, and discontinuation; and (3) assessing risk and addressing harms of opioid use (Dowell et al., 2016).

Key points:

- Long-term opioid use often begins with the treatment of acute pain.
- Prescribe the lowest effective dose possible.
- Non-opioid therapies are preferred for chronic pain.
- Establish treatment goals and reassess throughout treatment.
- Prescribe immediate-release opioids instead of extended-release/long-acting opioids.
- Evaluate benefits and harms within 1 to 4 weeks of starting opioid therapy.
- Evaluate risk factors for opioid-related harms.
- Use a validated screening tool. (NIDA, 2017)

In addition:

- Use Prescription Drug Monitoring Programs (PDMPs) to determine concurrent opioid use.
- Use urine drug test screening to test for concurrent illicit drug use.
- Avoid concurrent prescribing of other opioids and benzodiazepines if possible.
- Offer evidence-based treatment for opioid use disorders. (NIDA, 2017)

On January 1, 2018, the Joint Commission implemented revised pain assessment and management standards. The new standards, state that hospitals must:

- Establish a clinical leadership team.
- Engage medical staff and hospital leadership in improving pain assessment and management.
- Provide at least one non-pharmacologic pain treatment modality.
- Facilitate access to Prescription Drug Monitoring Programs.
- Concentrating on how pain is affecting patients' physical function.
- Engage patients in treatment decisions.
- Address patient education and engagement.
- Referral patients addicted to opioids to treatment programs. (Joint Commission, 2020)

Breaking the Stigma

The primary problem with the opioid epidemic is simple: It is easier to get high than it is to get help. People who need substance use treatment sometimes do not have access to treatment. Stigma surrounding substance use disorders remains high. To avoid stigmatizing a person, consider the following strategies:

- Avoid labels ("addict," "junkie," or "drug user").
- Use "person first" language.
- Understand that drug use falls along a continuum.
- Be aware of unintentional bias.
- Reflect on your own experiences.
- Understand that substance misuse is often linked to trauma.

5. Alternatives to Opioids for Pain Management

Opioids are associated with the potential risks of opioid-related adverse drug events (such as respiratory and gastrointestinal related events) and abuse or dependence, which can significantly increase the cost of medical care (Carter et al., 2020). For this reason, reducing opioid monotherapy,* and using nonopioid treatments, as well as complementary and alternative treatments, are important factors in the management of pain.

***Monotherapy:** the use of a single drug to treat a disease or condition.

Reducing the Use of Opioids

Effective pain management should focus on avoiding opioid monotherapy and reducing the doses used to treat acute pain. This approach involves the administration of various opioid and non-opioid agents that act on different sites, resulting in a synergistic* and additive** effect. The goal is to reduce opioid-related adverse drug events and their costs, as well as reducing the risks of opioid abuse or dependence (Carter et al., 2020).

***Synergistic:** combining the drugs leads to a larger effect than expected.

****Additive:** Occurs when two or more drugs combine to produce an effect greater than effect of either drug taken alone.

Non-opioid pharmacologic therapies include acetaminophen and/or non-steroidal anti-inflammatory drugs (NSAIDs). When NSAIDs and/or acetaminophen are included in treatment regimens with opioids for pain relief, an opioid-sparing* effect has been demonstrated (Carter et al., 2020).

***Opioid-sparing:** the use of drugs that allow a patient to feel a similar level of pain relief while taking fewer opioids.

Cannabis may also have an opioid-sparing effect, whereby a smaller dose of opioids provides equivalent analgesia when paired with cannabis. A growing number of studies involving patients who use cannabis to manage pain demonstrate reductions in the use of prescription analgesics along with favorable pain management outcomes. However, there is a lack of research from real-world settings exploring the opioid-sparing potential of cannabis among high-risk individuals who may be engaging in frequent illicit opioid use to manage pain (Lake et al., 2019).

Complementary and Integrative Approaches

A growing body of evidence suggests that complementary and integrative approaches can help manage some painful conditions. In fact, opioids may be less effective than nonopioid therapies for some acute and chronic pain conditions. Adding to the problem, opioids prescribed for surgery and other acute pain conditions often go unused, a potential source for diversion and misuse (AHRQ, 2020, January 2).

Complementary and integrative treatments include natural products such as vitamins, herbs, and probiotics; mind-body practices such as yoga, meditation, and naturopathy; and traditional Chinese medicine. At least 30% of the U.S. population uses complementary health approaches, most along with conventional treatments (Feinberg et al., 2018).

Research is lacking on demographic, lifestyle, and health-related factors for people using complementary health approaches for pain, and data is particularly sparse in underserved communities. Many of these communities have the highest rates of pain in the nation (e.g., arthritis), and have a rich anecdotal history of using natural products for pain management (Feinberg et al., 2018).

A 2017 review looked at which complementary approaches might be helpful for relieving chronic pain and reducing the need for opioid therapy. There was evidence that acupuncture, yoga, relaxation techniques, tai chi, massage, and osteopathic or spinal manipulation may have some benefit for chronic pain, but acupuncture was the only technique that reduced a patient's need for opioids (NCCIH, 2021).

Research shows that hypnosis is moderately effective in managing chronic pain, compared to mainstream medical care. However, the effectiveness of hypnosis varies from one person to another (NCCIH, 2021).

Studies of mindfulness meditation for chronic pain showed that it is associated with a small improvement in pain symptoms. Studies have shown that music can reduce self-reported pain and depression symptoms in people with chronic pain (NCCIH, 2021).

Coverage of Nonpharmacologic Treatments

CDC's 2016 *Guideline for Prescribing Opioids for Chronic Pain* recommended the use of nonopioid and nonpharmacologic therapies as first-line treatment for chronic pain. Consistent with other recent clinical practice guidelines, CDC also advises that if opioids are prescribed, they should be combined with nonpharmacologic and nonopioid therapies (Heyward et al., 2018).

An increasing volume of evidence and consensus demonstrates the benefits of many of these approaches in clinical practice. The use of nonopioid and nonpharmacologic therapies provides an opportunity to simultaneously improve the quality of care for those with pain while reducing overreliance on prescription opioids (Heyward et al., 2018).

Despite these recommendations, wide variation in insurance coverage of nonpharmacologic treatments remain. This may be driven by the absence of best practices, the administrative complexities of developing and revising coverage policies, and payers' economic incentives. Healthcare providers have an opportunity to improve the accessibility of services, reduce opioid use, and ultimately improve the quality of care for individuals with chronic non-cancer pain while alleviating the burden of opioid addiction and overdose (Heyward et al., 2018).

6. Drug Diversion

Drug diversion is the intentional removal of a prescription medication from the legitimate channels of distribution and dispensing. Diversion occurs when family or friends share a prescription medication, when medication is stolen from its intended recipient, or when a prescription medication is otherwise illegally acquired.

Prescription drug diversion, misuse, and abuse is an escalating public health problem. Its impact is associated with a high likelihood of poor healthcare outcomes, increased incarceration cases, and increased mortality. Worldwide, sedatives, analgesics, and stimulants are the drug classes most commonly diverted, misused, and abused (Chibi et al., 2020).

People of all ages, genders, and backgrounds use illicit or prescription drugs nonmedically. This can mean taking a medication in a manner or dose other than prescribed; taking someone else's prescription, even if for a legitimate medical complaint such as pain; or taking a medication to get high (NIDA, 2020, June).

Most Common Sources of Illicit Drugs

Once a person has made the decision to seek illicit drugs, they can find them in a number of ways: family, friends, doctor shopping, from healthcare providers, through fraud, and via the internet.

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 pain medications are so commonly prescribed, often nonmedical users merely look in the medicine cabinet of a family member or friend. Strikingly, 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

Patients may request prescription pain medications from more than one physician. The patient does not inform the doctors of the multiple prescribers and fills multiple prescriptions for the same or similar medication at different pharmacies. This is known as "doctor shopping." However, most opioids are obtained by prescription from one physician (Dixon, 2018).

After prescriptions for opioids nearly quadrupled in the early part of the century, states began efforts to identify individuals most at risk for opioid abuse and overdose. Doctor shopping was identified as a risk factor for opioid use disorder, overdose, and diversion. Many states, including New Jersey, have developed PDMP databases to flag patients who doctor shop (Schneberk et al., 2020).

Paradoxically, negative health outcomes can occur as denied patients pursue opioids through riskier channels or use more lethal forms of opioids. Although there is evidence that PDMPs may reduce overall opioid prescriptions, there is insufficient evidence to determine if PDMPs curtail doctor shopping behavior or reduce negative patient centered outcomes such as opioid overdoses (Schneberk et al., 2020).

Fraud

Patients who misuse or abuse prescription drugs may try to fill a fraudulent prescription, which come in many forms:

- Filling out a prescription for fictitious patient on a prescription pad stolen from a prescriber's office.
- Altering a legitimate prescription.
- Changing the phone number on a legitimate prescription pad with an altered call-back number.
- Calling in a fraudulent prescription and providing the drug abuser's own call-back number for verification.
- Create a fraudulent prescription signed by a fictitious doctor or copied from a legitimate doctor.

Healthcare Providers

Data suggest that about 10% of healthcare workers are abusing drugs. They may become involved in drug diversion by providing drugs to patients engaging in fraud or doctor shopping, or divert drugs for their own use.

Nonclinical healthcare workers may also divert drugs. Shipping-and-receiving personnel often handle drug shipments or returns and housekeeping may encounter partly filled vials in patient rooms. Patients and their families may also divert drugs by, for example, acquiring fentanyl patches from unsecured waste receptacles or tampering with unsecured intravenous infusions (Fan et al., 2019).

Due to the availability of, and access to, medications in healthcare organizations, diversion of controlled substances can be difficult to detect and prevent without a comprehensive controlled substances diversion-prevention program (Joint Commission, 2019).

Some of the ways in which controlled substances are diverted by a healthcare provider:

- Substitute drug is removed and administered while controlled substance is diverted.
- Prescription pads are diverted and forged to obtain controlled substances.
- Volume removed from premixed infusion.
- Multidose vial overfill diverted.
- Prepared syringe contents replaced with saline solution.
- Medication is documented as given but not administered to the patient.
- Controlled substance waste is removed from unsecure waste container.
- Expired controlled substances are diverted from holding area. (Joint Commission, 2019)

Case: Jan and Dora

Jan and Dora are advanced practice registered nurses who specialize in restructuring and rehabbing nursing homes that are on the brink of bankruptcy. They have had success "saving" several large nursing homes in New Jersey, are paid handsomely, and have the respect and gratitude of their employers. When they arrive at a failing facility, it isn't unusual for them to fire employees who have been engaged in illegal activities such as diversion of controlled substances.

On a visit to their home, a friend noticed a plastic bag filled with pills on a table next to a recliner. The friend, a registered nurse and recovered heroin addict, immediately recognized the drugs as prescription pain pills. She asked Jan where she got the pills and Jan replied that she had retrieved them from a garbage can in her office at the facility she and Dora were currently working to save from bankruptcy. When pressed for an explanation, Jan said that as far as she was concerned, once a drug is thrown into a garbage can, it no longer belonged to anyone and she was free to take possession.

The diversion of controlled drugs from hospitals affects patients, healthcare workers, hospitals, and the public. Patients suffer inadequate pain control and experience substandard care from impaired healthcare providers. Healthcare workers who divert are at risk of overdose and death; they also face regulatory censure, criminal prosecution, and civil malpractice suits (Fan et al., 2019).

Hospitals bear the cost of internal investigations and followup care for affected patients, and can be fined in excess of \$4 million dollars for inadequate safeguards. Hospitals that fail to regulate and report when diversion occurs compromise public trust (Fan et al., 2019).

Crypto Markets

The internet has facilitated the sale drugs for more than fifteen years, but when the first crypto market,* Silk Road 1, came online in 2011, illicit drugs began to be traded in large quantities. The annual turnover of drug sales conducted through crypto markets is estimated to be in the hundreds of millions of dollars, with most transactions involving recreational drugs such as cannabis and "ecstasy" (Martin et al., 2018).

***Crypto markets.** Crypto = cyber. Also known as *Cryptocurrency exchanges*, they are websites where individuals can buy, sell, or exchange cryptocurrencies for other digital currency or traditional currency. The exchanges can convert cryptocurrencies into major government-backed currencies, and can convert cryptocurrencies into other cryptocurrencies.

Before 2014, prescription drugs represented slightly less than 10% of all crypto market sales. Customers of crypto markets are believed to be predominantly male, young (<25 years), educated, employed, and white. Since 2011 crypto markets have been analyzed using automated software "crawlers" that collect publicly available data from websites (Martin et al., 2018).

In 2014, when the FDA rescheduled hydrocodone combination products from schedule III to the more restrictive schedule II, it became harder to get these drugs through a prescription, and especially repeat prescriptions. Restrictions had the unintended consequences of a displacement toward illicit substitutes such as heroin, oxycodone, and fentanyl. It has been suggested that the growing use of heroin and fentanyl in the United States is related to this prohibition, whereby interventions, such as increased enforcement and changes to drug scheduling, lead to illicit markets dominated by higher potency products (Martin et al., 2018).

The access of drugs through crypto markets might make it more difficult to reduce the harms associated with prescription opioids. With the move to an illicit market, it becomes more difficult to track use of prescription opioids gotten illegally and to offer treatment and help to users. Prohibition also suggests that the move to an illicit market is associated with use of increasingly potent drugs (Martin et al., 2018).

Percentages of Users by Source

Sources of prescription pain medication	Percentage
Free of charge from a relative or friend	40.5%
From a healthcare provider via prescription or by stealing	36.4%
From one doctor	34%
Bought or stolen from a relative or friend	9.4%
Bought from a dealer or stranger	4.9%
From more than one doctor	1.7%

Source: Dixon, 2018.

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Quiz NJ Abuse of Prescription Drugs (289)

1. Every year, about 50,000 people in the United States die from opioid overdoses.

- a. True
- b. False

2. Three practices have contributed to the opioid crisis. They are:

- a. Global warming, an aging U.S. population, and the pharmaceutical industry.
- b. The pharmaceutical industry, marijuana legalization, and lack of training for doctors and nurse practitioners.
- c. Adding pain as the 5th vital sign, the pharmaceutical industry, and lack of disclosures by some researchers and clinicians.
- d. The COVID pandemic, increased use of marijuana, and unscrupulous doctors.

3. The opioid crisis has been described as occurring in 3 waves. They are:

- a. Increase in U.S. population, increased use of heroin, and the development of Narcan.
- b. Increased opioid prescribing, increase in opioid deaths involving heroin, and a rise in synthetic opioid overdose deaths.
- c. Decreased opioid prescribing, increased overdose deaths from marijuana, and increased use of synthetic opioids.
- d. Increased use of opioids by older adults, increased use of Vicodin, and increased acceptance of opioids by the general population.

4. The 3 classes of most-abused prescriptions drugs are:

- a. Analgesics, hormonal agents, and sedatives.
- b. Antidepressants, sedatives, and anxiolytic agents.
- c. Antipsychotics, antibiotics, and antidepressants.
- d. Opioids, central nervous depressants, and stimulants.

5. The distinction between dependence and addiction is:

- a. Addiction can resolve after long-term detoxification but dependence is life-long.
- b. Only dependence can be healed without withdrawal symptoms.
- c. Dependence can resolve after detoxification but addiction has long-lasting effects.
- d. Only addiction is associated with brain abnormalities.

6. CDC has identified some problem areas related to the prescribing of opioids. They include:

- a. Not enough opioids are prescribed, and dosage is too low.

- b. Too many people are allergic to opioids.
- c. Too many days, too high a dose.
- d. Not enough days, too low a dose.

7. When prescribing opioids to treat chronic pain:

- a. Prescribe the lowest effective dose possible.
- b. Stress that chronic pain is psychological.
- c. Start with a very high dose.
- d. Try more than 1 opioid at the same time.

8. A key part of effective pain management is:

- a. Avoid opioid-sparing treatment regimens.
- b. Avoid opioid monotherapy and reduce the doses used to treat acute pain.
- c. Prescribe cannabis instead of opioids.
- d. Use opioids rather than non-steroidal anti-inflammatories.

9. 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.

10. What is the most commonly reported source of diverted prescription pain medications?

- a. Purchased from drug dealer.
- b. Stolen from healthcare provider.
- c. Prescribed by more than one doctor.
- d. Received from relation or friend.

Answer Sheet NJ Abuse of Prescription Drugs (289)

Name (Please print) _____

Date _____

Passing score is 80%

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

*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 _____ 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 Dept of Health website. _____ State board or professional association.
_____ Searching the Internet. _____ A friend.
_____ An advertisement. _____ I am a returning customer.
_____ My employer. _____ Social Media
_____ Other _____

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 and Payment Form (289)

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

*Name: _____

*Email: _____

*Address: _____

*City and State: _____

*Zip: _____

*Country: _____

*Phone: _____

*Professional Credentials/Designations:

*License Number and State: _____

Payment Options

You may pay by credit card, check or money order.

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

1 contact hour: \$10

Credit card information

*Name: _____

Address (if different from above):

*City and State: _____

*Zip: _____

*Card type: Visa Master Card American Express Discover

*Card number: _____

*CVS#: _____

*Expiration date: _____