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CURRENT COVERAGE OF TOPICS IN ADDICTION MEDICINE

Joshua Sonkiss, MD
Editor-in-Chief

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IN THIS ISSUE

Focus of the Month:
Prescription Drug Monitoring Programs (PDMPs)

Learning Objectives
After reading these articles, you should be able to:

1. Describe the role of PDMPs as a tool for curtailing controlled substance abuse. **2.** List some of the most effective ways for clinicians to identify and treat patients with drug-seeking behavior. **3.** Summarize some of the current findings in the literature regarding psychiatric treatment.

Identifying and Deterring Drug Abuse and Diversion via PDMPs

Talia Puzantian, PharmD, BCPP
Deputy Editor, The Carlat Psychiatry Report

Dr. Puzantian has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

David is a 30-year-old male referred by the department of corrections after spending two years in jail for drug possession. On interview, he says he has "extreme social anxiety" that's kept him out of work for several years. He also cites difficulty concentrating due to "adult ADD." He looks relaxed and comfortable, and says he can't recall the name of the doctor who once prescribed him Xanax and Adderall. He asks to restart these medications because "they're the only ones that work."

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Summary

- Over 66% of states require prescribers to sign up with and use their state's PDMP.
- Prescribers are encouraged to check their state's laws regarding privacy, disclosure, and sharing of information discovered via PDMP use; misuse can lead to criminal charges.
- Limitations to PDMP use are lack of up-to-date data and restrictions on the type of information PDMPs contain.

Q&A With the Expert

Managing Drug-Seeking Patients
Damon Raskin, MD

Private practice internist in Pacific Palisades, California. Specializes in the treatment of addiction and substance abuse.

Dr. Raskin has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CATR: What's your initial approach to patients who ask for controlled substances?
Dr. Raskin: First, it's important to exclude the possibility that someone may have an unrecognized or undertreated medical condition. In an addiction treatment setting, this has often been done before the patient sees you, but in other settings it can be more challenging. Once I've ruled out an underlying condition like severe pain, I like to begin by reviewing a prescription drug monitoring program (PDMP) database report to see if they've gotten prescriptions from other doctors, when, and how often. [Editor's note: See the lead article for more information on PDMPs.] After that, I sit down with the patient and say, "Let's look and see if these prescriptions are something that you really need for a medical condition, or if this has more to do with a possible addiction issue." And I always screen for alcohol metabolites in the urine tox screen that I perform on all patients.
CATR: What do you do after you've explored all these alternatives and concluded addiction is the main issue?

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Identifying and Deterring Drug Abuse and Diversion via PDMPs

Continued from page 1

We've all seen patients like David—patients who call requesting sedatives or stimulants, "must be seen right away," are "visiting from out of town," or have "lost a prescription." Sometimes it's just as they say, but often these are cover stories from drug-seeking patients. We've been taught in these situations to perform a thorough history and assessment, document, request identification, call previous providers, and—if we do write the prescription—to provide the drug in limited quantities. Now we have another tool: prescription drug monitoring programs, also known as PDMPs. Although PDMPs have been around for a few years, they've recently become more user-friendly—and for most controlled-substance prescribers, using them will soon be mandatory.

What are PDMPs?

PDMPs are searchable databases that can help prescribers identify potential abuse or diversion of controlled substances. They were created by the U.S. Department of Justice (DOJ) in 2009 to help law enforcement identify drug diversion. In many states, the PDMP is run by the state's board of pharmacy, but in some states, it may be managed by the department of health, law enforcement, or a professional licensing board. In California, for example, the DOJ manages the PDMP.

In most states, anyone licensed to prescribe controlled substances (including physicians, nurse practitioners, and physician assistants) as well as pharmacists have PDMP access. In fact, as of 2016, 29 states require prescribers to sign up with and use their state's PDMP. Most states will allow you to sign up online. The recent passage of the Comprehensive Addiction and Recovery Act, or CARA (see this issue's News of Note), aims to bolster the usefulness of PDMPs by increasing information-sharing between states and by ensuring that the information is up-to-date.

How do PDMPs work?

To search for a patient in a PDMP, all you need to do is enter the person's name and birthdate and click the search button. The PDMP will generate a patient activity report that will tell you what controlled substances the patient has picked up and where. The report gives you lots of detail, including the address of the patient; the drug names, doses, quantities, and refill information on any controlled substances that have been dispensed; and the applicable prescriber names, DEA numbers, pharmacy names, dispensing dates, and prescription numbers.

PDMPs provide contact information so practitioners can communicate directly with other prescribers and dispensers about a particular patient. Some PDMPs will also alert you with an on-screen pop-up warning if your patient meets pre-designated alert thresholds. For example, if your patient obtains controlled substances from 6 or more prescribers or pharmacies within a 6-month period, or is prescribed both a benzodiazepine and an opioid at the same time, you may receive an alert. Some PDMPs further allow you to flag patients with whom you have a controlled-substance contract (an exclusivity agreement that no other prescriber will provide controlled substances).

When you query your state's PDMP, David's report shows that he filled prescriptions for Adderall and Xanax from two other doctors in the past 30 days, and that he recently received oxycodone from three emergency departments in two cities.

What's the best way to use my state's PDMP?

Some states have a rule requiring you to check the PDMP before you can prescribe any controlled substance to any patient. Other states are more lax and allow you to decide when to check it.

Here are some commonsense guidelines. You should consider checking the PDMP before prescribing a controlled substance for:

- Patients who are new to your practice
- Patients with a history of substance use disorder
- Patients who refill early or report "losing" medication

In addition, it's a good idea to check the PDMP any time you have a gut feeling that your patient isn't telling the truth about controlled-substance use. For established patients, how often you recheck the database will depend on how frequently you see the patient, how much you trust the patient, and what your state laws require.

Since each state's PDMP is different, you should spend a little time familiarizing yourself with your state's program. To find your state's program, check with the PDMP Training and Technical Assistance Center (http://www.pdmpassist.org/content/state-pdmp-websites). Be advised, however, that this database may not always be up-to-date because of ever-changing PDMP laws and regulations.

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All editorial content is peer reviewed by the editorial board. Dr. Frenz, Dr. Galloway, Dr. Krenztman, Dr. Puzantian, Dr. Sonkiss, and Dr. Weaver have disclosed that they have no relevant financial or other interests in any commercial companies pertaining to this educational activity. This CE/CME activity is intended for psychologists, social workers, psychiatrists, and other mental health professionals with an interest in the diagnosis and treatment of addictive disorders.

Identifying and Deterring Drug Abuse and Diversion via PDMPs

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With whom can I share PDMP information?

In some states, it's legal for you to use PDMP information to contact other practitioners who have prescribed controlled substances to your patient. In those states, sharing this information with the other prescribers is usually a good idea, because otherwise the patient may keep getting inappropriate prescriptions. Similarly, some states allow you to share the PDMP reports with your patients. Doing so can be helpful for setting limits and engaging patients in controlled-substance contracts. But be careful—in other states, sharing information from PDMP reports may be a crime.

Regardless of state, if a PDMP report reveals that a patient has been lying to you or receiving controlled substances from multiple prescribers, one thing you *shouldn't* do is contact the police. Federal privacy laws prohibit this—under HIPAA, such disclosures can only be made if patients pose an imminent risk of harm to themselves or others. There's an interesting case-related discussion on Medscape about how to deal with lying patients at http://tinyurl.com/h3xnhm9. Be aware that there may be harsh penalties, such as felony charges, for inappropriate use of PDMPs. Unwarranted activities include checking on people who aren't your patients or accessing the database without a valid registration. Also, in some states, providing information to anyone else—including the patient you're querying or anyone to whom you transmit the patient's medical record—may be a criminal act.

Can I delegate the PDMP-checking chore to an employee?

Some states allow prescribers and dispensers to register delegates whom they authorize to conduct PDMP searches on their behalf. But before you ask a staff member to search the database for you, make sure you fully understand the laws in your jurisdiction. In Alaska, for example, asking someone to check the PDMP for you is asking that person to commit a felony.

What are some problems inherent in PDMP use?

While they are excellent tools, PDMPs have several limitations. The first thing to keep in mind is that PDMPs may not be up-to-date at the moment you query them. The report you generate is not necessarily a real-time snapshot of your patient's controlled-substance access, since pharmacies have varied requirements for reporting the controlled substances they dispense. Updates range from daily to monthly, and most PDMPs contain information for up to 12 months.

The second problem is that there's a surprising amount of information PDMPs don't contain. For example, mail-ordered prescriptions from out of state won't be included in your report. Nor will prescriptions coming from federal healthcare facilities such as Veterans Affairs facilities, the Department of Defense, Indian Health Service, and other agencies that are not required (and often do not) report to state PDMPs. In addition, federally funded methadone programs and some buprenorphine maintenance programs are bound to additional confidentiality regulations. Specifically, 42 *CFR* Part 2 imposes strict limits on sharing substance abuse treatment information with third parties. For more information, visit this SAMHSA web page: http://www.samhsa.gov/about-us/who-we-are/laws/confidentiality-regulations-faqs.

The third problem is with drug-seeking patients looking to game the system. For example, patients may use a variation of their name to try and secure multiple prescriptions. You may be able to partially counteract this with some clever searching. For example, searching "Ronald McDonald" may result in a report showing only one prescription dispensed, but searching with the patient's initials and birthdate rather than his full name may generate dispensing records for the same patient under the names Ron McDonald, Ronny McDonald, R. McDonald, etc.

What should prescribers do in light of these problems? A recent Florida Supreme Court decision indicated law prosecutors in controlled-substance cases should not assume that data in PDMPs is accurate, and instead should regard the data as "justification for further inquiry" (*Hardy v. State of Florida,* 2014 Fla.App. LEXIS 7172; full decision available at http://law.justia.com/cases/florida/first-district-court-of-appeal/2014/1d13-0698.html). This is probably sound advice for prescribers as well. A good article on this subject can be found at https://www.pharmacist.com/pdmp-report-justifies-further-inquiry.

When you inform him of the recent prescriptions you found in his PDMP report and express concern he might have a substance abuse problem, David scoffs and walks out of your office without saying a word. [Editor's note: See our expert interview with Dr. Raskin for suggestions about how to respond in these situations.]

Resources for More Information on PDMPs

Resource	Information
PDMP Training and Technical Assistance Center www.pdmpassist.org	Your state program's content and profile information; current news and events
Centers for Disease Control and Prevention www.cdc.gov/drugoverdose/pdmp	General information for providers and states; state successes
US DOJ Bureau of Justice Assistance www.bja.gov/ProgramDetails.aspx?Program_ID=72	DOJ performance reports and findings

CATR VERDICT:

As of 2016, the majority of states require controlled substance prescribers to register for and begin using PDMPs, and that number is increasing. While PDMPs can help identify patients at high risk of abusing or diverting controlled substances, they're not 100% reliable, and they're subject to confusing regulations that vary from state to state. If you prescribe controlled substances, it's a good idea to learn about your state's PDMP laws, consider your search results in the context of all available information, and watch for regulatory changes over the next few years.

Expert Interview

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Dr. Raskin: I tell the patient my opinion in the most gentle, straightforward way I can. I will say, "Look, for medical purposes, I think that you do have a true problem, and it's called addiction." I don't just say, "Get off these drugs," or, "I'm not going to give you these drugs." If patients are ready to accept they might have a substance use disorder, then I will offer to help them. I will say, "Look, I have the knowledge and the ability to help you get off these medications. If you are willing to work with me, I can help you—whether that means an inpatient program or an outpatient program or medication-assisted therapy with drugs like buprenorphine, which I'm certified to give."

"I don't just tell patients, 'I'm not giving this to you.' I want to offer them real solutions for the problem they have, and they can always come back when they are ready."

Damon Raskin, MD

CATR: What about patients who don't agree they have a problem with addiction?

Dr. Raskin: If a patient isn't ready to explore that possibility and just insists on a prescription, then unfortunately I can't have that in my practice, and I have to let them go. Usually, I don't have to actually fire them or send them a letter of dismissal—they leave when they realize they aren't going to get what they want. But again, I don't just tell patients, "I'm not giving this to you." I want to offer them real solutions for the problem they have, and they can always come back when they are ready.

CATR: That sounds like good advice. Let's talk about some common scenarios. Do you have any strategies that could help our readers decide when a patient who is requesting opioids is endorsing more pain than they actually have?

Dr. Raskin: It's tricky. The fact is there is no great measure or marker of pain, and even after 20 years as a practicing internist, I often rely on my gut instinct. But I'll also look carefully at the patient's history and exam. For example, clues like elevated blood pressure and body language can indicate when someone is in pain. Talking to family members can occasionally be helpful. One very useful clue is whether someone is willing to explore alternative therapies for pain. For example, if it's back pain, is the patient willing to see someone for an epidural injection, consider physical therapy, or try a mindfulness group? If they are, they are much more likely to have a legitimate pain problem. On the other end of the spectrum, there are patients who reject alternatives and say, "This is what I have to have—my 8 Percocet a day." In that case I'm going to say, "I'm not comfortable with that, although I can help you detox and I can help you in other ways."

CATR: Interesting. What about sedative-hypnotics? For example, what do you say to patients who complain of severe anxiety and insist benzodiazepines are the only thing that help them?

Dr. Raskin: This happens a lot, and I usually start by educating patients. I explain to them that benzodiazepines are indicated for short-term use and for acute panic attacks once in a while, but that they are addictive and have serious side effects like memory impairment, fatigue, and sedation. And I say, "Look, this is a situation where we have to get to the root of the problem. Benzodiazepines are like a Band-Aid for a wound, a wound that needs actual treatment." I explain, "If there is a true anxiety disorder, then we need to look at a treatment that will not just cover it up. We need to consider an SSRI or an SNRI, or maybe cognitive behavioral therapy if we don't want to deal with medications." If I get the sense that there is a benzodiazepine addiction issue—if a patient is getting them from multiple sources, asking to fill prescriptions earlier, etc—sometimes I'll just confront the patient.

CATR: What do you say?

Dr. Raskin: Something along the lines of, "Look, I think you might be addicted to this type of medication, and I'm qualified to help you get off of it." And if they continue to insist that benzos are the only thing that works, I'm going to say, "Well, that's not something that I feel comfortable with." You have to sort of set boundaries with these patients.

CATR: What about when patients ask for stimulants? How do you weed out true ADHD cases from not-so-true ones?

Dr. Raskin: Well, first of all, there's no question stimulant medications are overprescribed, and there are a lot of people who claim they have ADHD who really don't. When patients complain of ADHD symptoms, it's important to ask how long they've had them. If they were diagnosed in childhood and they needed stimulants to get through school—and school records can tell you that—then that's one thing. But if I have a patient that aced high school, went to Yale, and finished law school, and now just needs some Adderall to help them through a case to impress the senior partner, that's an illegitimate use of the drug.

CATR: So how do you handle these patients?

Dr. Raskin: If I don't think a patient has true ADHD, I'll explain to them the hazards and side effects of stimulant medications, like insomnia, anxiety, heart palpitations, elevated blood pressure, and decreased appetite—those types of things. And I tell them that these medications don't necessarily help patients without true ADHD. In today's society, we're all trying to get so much done in a day, and life is stressful. I'll ask the patient, "Look, is this something that can be managed with changing some behaviors? Is it something that can be managed with just prioritizing?" For some patients, it may be appropriate to offer a non-stimulant medication like atomoxetine that doesn't have any addictive properties. Or sometimes I'll offer a patient bupropion if I think there's an element of depression that could account for lack of concentration, focus, or motivation. But for those patients who insist they need stimulants for ADHD, but I'm not convinced, I'll often refer them for cognitive testing.

CATR: Doctors often inherit patients who are already taking high doses or combinations of controlled substances that they're not comfortable prescribing. How can they get those patients to accept coming back down to safe dosing levels?

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News of Note

Buprenorphine Treatment to Be Expanded

Two recent federal initiatives have catapulted buprenorphine to the forefront of treatment for opioid use disorders. On July 6, 2016, the federal Department of Health and Human Services (HHS) published a final rule that raised the number of patients a single physician can treat from 100 to 275. Then, on July 22, President Obama signed the Comprehensive Addiction and Recovery Act (CARA), which adds midlevel providers—nurse practitioners (NP) and physician assistants (PA)—as buprenorphine prescribers. Other provisions of CARA increase the use of naloxone for opioid overdose rescue (see article in *CATR*, September/October 2016) and strengthen prescription drug monitoring program databases (see lead article in this issue).

The final rule expanding the cap was published in the *Federal Register* on July 8. It raises the total number of buprenorphine patients a waivered physician can treat from 30 in the first year and 100 in subsequent years to a total of 275. This is a big increase, but it isn't automatic. Even if you are already a buprenorphine prescriber, increasing your "panel" to 275 patients isn't just a matter of inviting more patients into your practice. You must first request and be granted the increase, and it's only available to two classes of physicians: those who possess subspecialty board certification in addiction medicine or addiction psychiatry, and those who practice—without subspecialty certification—in a qualified practice setting as defined by the final rule.

Critics of federal policy on medication-assisted treatment have long objected that while NPs and PAs can prescribe opioids for other purposes with few limits, drug enforcement laws have prohibited them from prescribing controlled substances for addiction treatment. Expanding buprenorphine waivers to NPs and PAs will be welcome news for many, but some differences will remain between physicians and midlevels who prescribe buprenorphine. For example, to qualify for a waiver, physicians must complete an eight-hour training course

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Expert Interview

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Dr. Raskin: This happened to me. There was a doctor who retired a few years back in a town where I used to practice, and he just loved to prescribe big doses of narcotics. I inherited quite a few of his patients, and they were all really happy. And they were not young people looking to get high; they were 70-year-old men and women on 6 or 8 Percocet a day for back pain, fibromyalgia, headaches, and these types of things. With patients like this, I don't just say, "Hey, I'm going to take you off these drugs" because that doesn't help them. But I do try to explain the dangers of these drugs—the hazards of confusion, falls, car accidents, and so on. These conversations are especially important with older patients, and especially if we're combining benzodiazepines, opiates, and other sedating medications.

CATR: That's true. What's your usual protocol for reducing levels?

Dr. Raskin: After explaining the rationale, I'll try to reduce the medications slowly and strategically. I might convert a short-acting narcotic to a long-acting narcotic, for example, and then try to add in some adjunctive therapy. For example, if I believe there is a legitimate pain issue, then I'll evaluate if that patient might be a good candidate for nonsteroidal anti-inflammatory drugs. I'll think about whether they're a good candidate for other medications like gabapentin, pregabalin, duloxetine, or tricyclic antidepressants. These alternatives can be used to help with pain as well as facilitate reducing the narcotics. Finally, and this is extremely important, I'll talk to patients about things they can do that don't involve drugs, like physical therapy, meditation, and acupuncture, that have a role in treating chronic pain.

CATR: There is a new black box warning for combining benzodiazepines and opioids. Could that provide a new tool for doctors to negotiate with medication-seeking patients?

Dr. Raskin: Absolutely. It's nice to be able to say, "You know what? This is contraindicated, and there have been some good studies to say that this is a dangerous combination, so let's see what we can do to not have you be on this combination." So, again, it's a good tool to use when you're talking to your patients.

CATR: Patients occasionally threaten doctors with legal action if they don't get what they want. Do you have any advice for handling that situation?

Dr. Raskin: I think the best way to protect yourself as physicians is to document the conversation, including your concerns and why you are not prescribing the requested medication. That should be enough protection. After all, there is nothing that says doctors have to prescribe controlled substances just because a patient wants them.

CATR: Do you have any advice for doctors who feel beholden to patient satisfaction scores and are afraid they'll lose revenue if they say "no" to drug-seeking patients?

Dr. Raskin: I think of the Hippocratic Oath that we take when we become doctors. It's about patients' best interests, not satisfaction surveys. If we continue to give patients something we feel is not in their best interests just to make them happy, then that's not fulfilling our oath. It's an ethical issue and a moral one. We go into medicine to help people, not to harm them. And remember, saying "no" to a drug-seeking patient doesn't mean you're abandoning the patient. You can still offer addiction treatment or referral to an addiction specialist.

CATR: Thanks very much for your time, Dr. Raskin.

Research Updates

Bret A. Moore, Psy.D, ABPP

Dr. Moore has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

SMOKING

E-Cigarette Use Increases Quit Rates in England

REVIEW OF: Beard E, West R, Michie S, et al. Association between electronic cigarette use and changes in quit attempts, success of quit attempts, use of smoking cessation pharmacotherapy, and use of stop smoking services in England: time series analysis of population trends. *British Medical Journal* 2016;354:i4645.
STUDY TYPE: Time series analysis

Do electronic cigarettes (e-cigs) help people quit smoking tobacco cigarettes? Clinical trials have indicated that e-cigs are as effective as nicotine replacement therapy (NRT) in quit rates, but what about population-level evidence? Can it show that increasing e-cig popularity in a country leads to a greater likelihood of quitting smoking?

To explore this issue, researchers from England drew on data from two national databases that house smoking information about British citizens. Specifically, they looked at over 170,000 tobacco smokers aged 16 and older to see if e-cig use was associated with quit attempts, rates of successful quitting, and the use of medications and support programs that aid quitting. The data collected was based on quarterly self-reports from smokers over a 10-year period. The study did not exclude patients with mental illness, nor did it stratify subjects by the severity of their smoking habits.

RESULTS

Use of e-cigs was indeed associated with quitting smoking. For every 1% increase in the prevalence of e-cig use by smokers, there was a 0.1% increase in quit rates. However, increasing use of e-cigs didn't affect the rate of attempts to quit, use of NRT, use of prescription medications like varenicline and bupropion, or the use of behavioral support.

CATR'S TAKE

This is an important study because it's the first to examine the impact of e-cig use on smoking behavior in a large countrywide epidemiological study. We can be more confident that e-cig use helps people to quit smoking—at least in England.

PRACTICE IMPLICATIONS

This is yet another study endorsing the controversial practice of recommending e-cigs to smokers who want to quit. Many of us balk at the idea of prescribing e-cigs, and the fact is we don't know their long-term effects. Since we do know that NRT, bupropion, and varenicline are safe and effective for smoking cessation, these should be recommended first. But if these treatments fail or if patients insist on trying e-cigs for smoking cessation, we shouldn't discourage them. As new e-cig data comes in, it's likely we will be more tempted to endorse this latest method of kicking the habit.

ALCOHOL

Heavy Alcohol Use and History of Alcohol Dependence Lead to Cognitive Problems Later in Life

REVIEW OF: Woods AJ, Porges EC, Bryant VE, et al. Current heavy alcohol consumption is associated with greater cognitive impairment in older adults. *Alcoholism: Clinical and Experimental Research* 2016; ahead of publication.
STUDY TYPE: Quasi-experimental study

There are a few truths when it comes to cognitive functioning and acute alcohol use. We know that alcohol intoxication can lead to imbalance, disorientation, and loss of consciousness. We also know the ability to hang on to small amounts of information for a few seconds is impaired. However, what's less clear is the long-term impact on cognitive abilities in heavy drinkers as they age. It may seem like a "no-brainer" that cognitive abilities would be worse in heavy drinkers as they get older, but research on the topic has been conflicting.

In an attempt to gain a clearer answer to this question, 66 individuals between the ages of 21 and 69 (mean age was 38.5) were classified as either heavy drinkers (n = 21) or low-risk drinkers (n = 45). Heavy drinkers were defined as 5 or more drinks per day or more than 14 per week for men, and 4 or more per day or an average of 7 per week for women. The low-risk group consisted of individuals who drank less than the heavy group or not at all. The researchers collected information about alcohol use history, and administered a comprehensive battery of tests measuring global cognitive functioning, attention/executive function, learning, memory, motor and verbal function, and processing speed.

RESULTS

Older (40 and over) heavy drinkers did worse in the areas of learning, memory, motor skills, and overall cognitive ability compared to younger heavy drinkers. The same was true for heavy versus low-risk drinkers. Interestingly, those with a documented history of alcohol dependence, regardless of age or whether they were considered heavy or low-risk drinkers, performed worse in these same areas. A history of alcohol dependence seems to put drinkers at any level at greater risk for cognitive problems down the road.

CATR'S TAKE

Although this was a fairly small study, the findings are clear that heavy drinking, with or without alcohol dependence, is associated with memory and overall cognitive impairment. This was not likely to simply be a function of age-related cognitive decline, since these patients were relatively young, with a mean age of 38.5 and nobody over the age of 65.

PRACTICE IMPLICATIONS

If you have hard-drinking patients who are not motivated to moderate their drinking, you should tell them that recent research shows a clear association between heavy drinking and memory and learning problems. Many patients will probably be receptive to at least experimenting with a period of sobriety (say, a month or more) to see if they feel mentally sharper. More than likely, many of them will.

CE/CME Post-Test

This CME test is only available to active subscribers and it must be taken by December 31, 2017. If your subscription expires before that date, you will not have access to the test until your subscription is renewed. To earn CME or CE credit, you must read the articles and then take the post-test at www.TheCarlatReport.com. You must answer at least four questions correctly to earn credit. You will be given two attempts to pass the test. As a subscriber to *CATR*, you already have a username and password to log onto www.TheCarlatReport.com. To obtain your username and password, please email info@thecarlatreport.com or call 978-499-0583.

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Below are the questions for this month's CE/CME post-test. This page is intended as a study guide. Please complete the test online at www.carlataddictiontreatment.com. Note: Learning objectives are listed on page 1.

1. Which course of action should a clinician take if a PDMP report reveals that a patient has been receiving controlled substances from multiple prescribers? (LO #1)
   [ ] a. Assume there's no legitimate reason this might have occurred
   [ ] b. Delegate further PDMP queries for the patient to your administrative or legal department
   [ ] c. Contact the police or local law enforcement
   [ ] d. Consider local laws and other sources of information before discussing the report with the patient

2. According to Dr. Raskin, which of the following is true about working with patients who ask for controlled substances? (LO #2)
   [ ] a. It's important to exclude the possibility of an unrecognized medical condition
   [ ] b. It's usually necessary to fire medication-seeking patients to make them go away
   [ ] c. The physical exam has little importance in determining how much pain someone is experiencing
   [ ] d. Black box warnings are unlikely to be useful in dealing with medication-seeking patients

3. In compliance with federal law, all prescribers must register for their state's PDMP. (LO #1)
   [ ] a. True [ ] b. False

4. According to Dr. Raskin, which of the following statements is least likely to yield good results when working with a benzodiazepine-seeking patient? (LO #2)
   [ ] a. "I'm going to take you off these drugs."
   [ ] b. "Benzodiazepines are like a Band-Aid for a wound."
   [ ] c. "I think you might be addicted to this type of medication."
   [ ] d. "There have been some good studies that show this combination of medicines is dangerous."

5. In a recent study, what was the effect on smoking quit rates for every 1% increase in the prevalence of e-cigarette use by smokers? (LO #3)
   [ ] a. Increased .01% [ ] b. Decreased 0.1% [ ] c. Increased 0.1% [ ] d. Did not change

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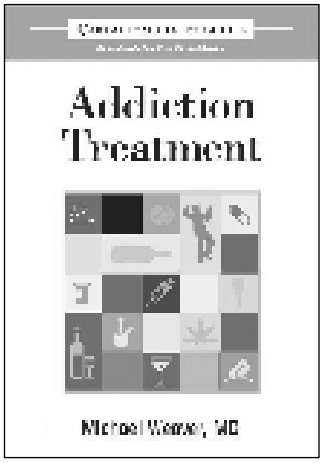

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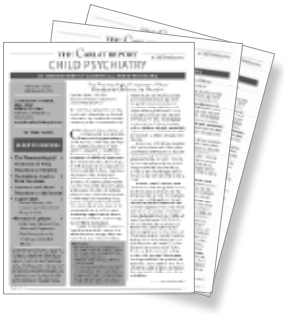

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News of Note

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through an organization approved by the Substance Abuse and Mental Health Services Administration. By contrast, CARA specifies that the waiver for NPs and PAs will require 24 hours of training. CARA gives HHS 18 months to work out the details of requirements for NPs and PAs.

More than 70 people a day die from opioid overdoses in the U.S., and both CARA and the new final rule were intended to help meet the demand for medication-assisted treatment. But so far, little funding has been provided to support these measures. For example, Congress authorized $181 million for CARA, but in the month of September, only $7 million was provided in a stopgap funding bill intended to keep the government going until December 9, 2016.

For more information on CARA, see: https://www.congress.gov/bill/114th-congress/senate-bill/524

For the buprenorphine cap final rule, see: https://www.federalregister.gov/documents/2016/07/08/2016-16120/medication-assisted-treatment-for-opioid-use-disorders

Alison Knopf is the editor of Alcoholism & Drug Abuse Weekly *and a freelance journalist specializing in mental health and substance use issues.*

Ms. Knopf has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

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