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I, Angela M Sefcik , hereby submit this original work as part of the requirements for the degree of Master of Public Health in Public Health - Health Education/Health Promotion.

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10492

Emergency Department Health Care Provider Perceptions of the Drug-seeking Patient

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Abstract

AN ABSTRACT OF THE THESIS FOR THE MASTERS OF PUBLIC HEALTH DEGREE IN
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TITLE: Emergency Department Health Care Provider Perceptions of the Drug-seeking Patient

MASTERS COMMITTEE MEMBERS: Dr. Rebecca Vidourek, Chair

Dr. Keith King

The purpose of purpose of the current study was to determine emergency department health care providers' perceptions of the drug-seeking patient in the emergency department and to determine factors that effect opioid prescribing habits. Analyses were also conducted to examine whether there was an effect in number of barriers to helping the drug-seeking patient, frequency of following drug-seeking patient protocol, confidence in identifying the drug-seeking patient, and importance of identifying the drug-seeking patient based on sex, title and years in current position.

A convenience sample of 144 participants were surveyed during February of 2014. The sample included health care providers with prescribing abilities from an academic-based institution. Descriptive statistics, one-way analyses of variance, and multivariate analyses of variance were used to analyze the data. Results indicated that there were no significant differences in the perceived number of barriers to helping a drug-seeking patient with their drug abuse problem, frequency of following ED drug-seeking patient protocol, confidence in identifying the drug-seeking patient, and importance of identifying the drug-seeking patient based on sex, title, and years in current position. Recommendations have been included for practice and future studies.

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Chapter 1

The Problem

Prescription drug addiction has been named a major public health problem by the Centers for Disease Control and Prevention (CDC), with the number of overdose deaths from prescription drugs exceeding those of motor vehicle accidents as the number one accidental cause of death in Americans (CDC, 2011). In 2008, there were nearly 15,000 deaths from prescription painkillers alone in the United States (CDC, 2011). In 2009, abuse and misuse of prescription analgesics resulted in 475,000 emergency room visits (Substance Abuse and Mental Health Association; SAMSHA, 2011).

The term “drug-seeking behavior” is loosely defined as a patients’ manipulative behavior to obtain a drug of their choice, most often for abuse (Longo, Parran, Johnson, Kinsey, 2000). It is estimated that for an emergency room that sees 75,000 patients annually, 262 patients per month are said to be exhibiting drug-seeking behavior (Hansen, 2005).

There have been shown to be a variety of differences based on sex, race, and ethnicity in prescription drug abuse. In general, women are at a greater risk of abusing prescription drugs, because on average they are exposed to more psychoactive medications (Simoni-Wastila, 1998; Simoni-Wastila, Ritter, & Strickler, 2004). Women are 33% more likely to be prescribed a narcotic analgesic and 37% more likely to be prescribed a minor tranquilizer (1998). Additionally, probability of non-medical use of prescription drugs (NMPDU) in the past year is 54% higher for females than males (Simoni-Wastila, Ritter, & Strickler, 2004). Although many studies indicate that women are at higher risk, other studies have found that there is a higher prevalence of men with prescription use disorders (Kroutil et al., 2006, McCabe et al., 2006). In

terms of race and ethnicity, whites have been much more likely to report prescription drug abuse in adults aged 18-25 (McCabe et al., 2006; McCabe et al., 2005; Ford & Arrastia, 2008).

Differences have been found in percentage of NMPDU based on age. According to the 2012 National Survey on Drug Use and Health, 28% of respondents aged 18-25 reported NMPDU and 21% of respondents older than 25 reported NMPDU (SAMSHA, 2013). Vidourek, King, & Merianos (2013) found that in younger populations in grades 7th-12th, 12.4% of females and 14.5% of males had engaged in non-medical use of prescription drugs in their lifetime. In elderly populations, one study found that 16% of the elderly persons in the study using prescription drugs were classified as having a drug use disorder (Finlayson & Davis, 1994). The elderly population is often forgotten about in the discussion of prescription drug abuse, however, while most elderly people on average take multiple types of prescription drugs, it is important to note this demographic as being at risk for misuse and abuse.

There are many consequences of prescription drug misuse. The most acute danger is overdose, which has the potential to be life threatening. Prescription drug abuse and overdoses have been rising steadily since 1999 (Alexander, Kruszewski, & Webster, 2012). One study examining prescription drug abusers' overdose history found that 28% had experienced at least one lifetime overdose, with heavy use being the leading factor of overdose (Bonar, Ilgen, Walton, & Bohnert, 2014). Overdoses are often caused by other drug interactions or respiratory depression. Respiratory depression shows to be one of the most dangerous side effects of the opiates prescription drugs caused by an overdose, leading to hypoxia and or pulmonary edema, and potentially causing death (White & Irvine, 1999).

Many public health problems have been the result of prescription drug abuse. One public health consequence of drug abuse is the spread of communicable diseases including hepatitis C,

HIV, and even tuberculosis (Leshner, 1997). A burden has been placed on both the physical and mental health care treatment system in response to the rising prescription drug problem. Some of the health effects associated with prescription drug abuse include tachycardia, acute and long-term cognitive impairment, mental health problems, as well as organ damage (Caplan, Epstein, Quinn, Stevens, & Stern, 2007; Teter, Falone, Cranford, Boyd, & McCabe, 2010; Leshner, 1997). Each of these problems requires the use of emergency departments and doctor's room visits. Furthermore, the burden on the treatment system shows to be another public health concern. From 2004 to 2006, nearly 250,000 people enrolled in treatment for prescription drug abuse alone (SAMSHA, 2009).

Doctors and emergency departments (EDs) are often the target of many people looking for prescription drugs to misuse or abuse. According to the most recent National Survey on Drug Use and Health, more than half of people that misuse prescription drugs get them from a relative, with 86% of those relatives receiving their prescriptions from one or more doctors (SAMSHA, 2013). Since doctors are often the source of many abused prescription drugs, it is their responsibility to ensure that the drugs they are prescribing are being used for therapeutic purposes. Some ways doctors and hospitals can prevent drugs from being abused is by limiting the prescription of high daily doses or long-acting doses, checking prescription drug monitoring program systems for additional prescriptions, and using third party payer system to track patient histories of drug abuse and misuse (Logan, Liu, Paulozzi, Zhan, & Jones, 2013).

Many emergency departments have begun screening for prescription drug abuse problems in their patients and being used as the gateway for intervention. Although lack of time is generally a concern for emergency department providers in offering help to prescription drug addicts, the Screening, Brief Interventions, Referral to Treatment (SBIRT) program has shown to

be effective in healthcare sites in reducing drug abuse and improving health outcomes of its participants (Madras et al., 2009).

Although a variety of prescriptions have been known for abuse including, sedative-hypnotics (e.g. phenobarbital, flurazepam, methaqualone), stimulants (e.g. amphetamine, methamphetamine), tranquilizers (e.g. buspirone, clonazepam, diazepam, lorazepam), and opioids (e.g. codeine, oxycodone, morphine, hydrocodone), this study aims to focus on care provider perceptions of opioid drug-seeking patients in the ED (Huang et al., 2006). By examining health care provider's beliefs about their prescribing habits, a greater understanding may be found regarding this patient population and how they are managed.

Statement of the Problem

The purpose of the present study is to examine emergency department (ED) health care providers perceptions and practices of the drug-seeking patient in order to better serve this patient population. This study serves to examine how emergency department health care providers prescribe and how they view this frequently cared for patient population.

Research Questions

This study examines the following research questions:

1. How confident do health professionals feel in identifying a drug-seeking patient?
2. How important is it to identify drug-seeking patients in the ED?
3. What are the most common barriers to effectively helping drug-seeking patients in the ED?
4. How important do health professionals feel ED procedures help to reduce drug-seeking behavior?

5. Does perceived confidence, importance, frequency, and number of barriers differ based on sex, discipline, and number of years worked in the profession?

Hypotheses

Null hypothesis 1. There will be no significant differences in health professionals' confidence in identifying a drug-seeking patient based on sex.

Null hypothesis 2. There will be no significant differences in health professionals' confidence in identifying a drug-seeking patient based on title.

Null hypothesis 3. There will be no significant differences in health professionals' confidence in identifying a drug-seeking patient based on years in current position.

Null hypothesis 4. There will be no differences in perceived importance of identifying a drug-seeking patient based on sex.

Null hypothesis 5. There will be no differences in perceived importance of identifying a drug-seeking patient based on title.

Null hypothesis 6. There will be no differences in perceived importance of identifying a drug-seeking patient based on years in current position.

Null hypothesis 7. There will be no difference in frequency of identifying a drug-seeking patient based on sex.

Null hypothesis 8. There will be no difference in frequency of identifying a drug-seeking patient based on title.

Null hypothesis 9. There will be no difference in frequency of identifying a drug-seeking patient based on years in current position.

Null hypothesis 10. There will be no difference in the number of barriers to identifying a

drug-seeking patient based on sex.

Null hypothesis 11. There will be no difference in the number of barriers to identifying a drug-seeking patient based on title.

Null hypothesis 12. There will be no difference in the number of barriers to identifying a drug-seeking patient based on years in current position.

Operational Definitions

1. Prescription drug abuse – Using prescription medication without a prescription, in a way other than it was prescribed, or for specific feelings obtained from taking the medication.
2. Drug-seeking Behavior – The falsifying or exaggeration of symptoms in order to obtain prescription drugs from a health care provider to use for nontherapeutic reasons or for diversion.
3. Physical Dependence – Continued abuse of a substance where physical tolerance occurs and withdrawal symptoms arise if substance use is discontinued.
4. Drug Addiction – A long-term disease that involves continued and habitual use of a substance despite negative health, social, and legal consequences.

Delimitations

1. This study was delimited to emergency department physician's assistants, resident physicians, attending physicians, and nurse practitioners during February of 2014.
2. The study only included emergency department providers with prescribing abilities, excluding nurse practitioners, and therefore, may not be representative of all University of Cincinnati emergency department health care providers.

Limitations

This study was limited by: the self-reporting accuracy and honesty of the participants, and the participants' ability to read and understand the questionnaire.

Assumptions

For the purpose of this study it was assumed that all health care providers understood and completed the survey as accurately and honestly as possible.

Chapter 2

Review of the Literature

Prescription drug abuse is defined as the use of medication without a prescription, in a way other than prescribed, or for the experience or feelings elicited (NIDA, 2011). Prescription drug abuse rates and overdoses, especially those of opioids have been steadily increasing since 1999 (Alexander, Kruszewski, & Webster, 2012). The American Psychiatric Association (APA) defines substance abuse as a maladaptive pattern of substance abuse leading to clinically significant impairment or distress is manifested by one or more of the following within a 12-month period: recurrent substance use resulting in a failure to fulfill major obligations, participation in situations which are physically hazardous, legal problems, continued use of the substance despite social or interpersonal problems (APA, 2000). The National Institute on Drug Abuse (NIDA), describes “drug addiction” as a long-term disease characterized by habitual drug seeking and use despite negative consequences (NIDA, 2012). Some symptoms of drug abuse may include legal problems, failure to fulfill obligations, and participation in situations that are physically hazardous (2012). Physical dependence may occur when a person is using or abusing drugs, but should not be confused with the term dependence. According to NIDA, physical dependence occurs from continued use of a drug with increased tolerance for the substance where physical withdrawal symptoms arise when the drug is abruptly discontinued (2012). Symptoms of dependence of a drug include taking the drug in larger quantities, inability to cut down on drug use, and spending large amounts of daily time on obtaining the drug (2012). Prescription drug abuse occurs when prescription drugs are taken for reasons or in amounts not intended and as such, fall within APA criteria of drug abuse (NIDA, 2012).

Additionally, drugs obtained for nontherapeutic reasons can be misused or deferred for sale in the illegal drug market. Misuse of a drug can include abuse of the drug, and using the medication other than directed by a health care provider, diversion, or using a medication as intended, but which was not prescribed to you personally (Weiner et al., 2013). “Diversion” involves the unlawful distribution of medications obtained from healthcare providers (Rigg, March, & Inciardi, 2010).

Some important agents that can influence whether or not a substance has the risk of abuse include dose, route of administration, co-administration with other drugs, as well as context and expectations (Compton & Volkow, 2006). The dose of most opioid pain relievers gives insight as to how the drug can so easily become addictive. The dose of an opioid pain reliever used to control severe pain may be the same amount used to get high (2006). Therefore, if a patient describes high levels of pain, it would not be unreasonable for an emergency room provider to give them enough medication to get “high”, the reinforcing agent that fuels addiction. Route of administration provides an important aspect of prescription pain reliever addiction. Even when drugs are given in pill form, many drug abusers will alter the medication so that it may be administered through injection and inhalation, giving a faster rate of onset and a more intense, addiction reinforcing “high” (2006). Additionally, co-ingestion of other substances with psychoactive properties alongside opioids will enhance the “high” feeling and reinforce addiction (Preston, Griffiths, Cone, Darwin, & Gorodetzky, 1986).

Classic behaviors of the drug-seeking patient have been described in the literature (e.g. complaining of headaches, requesting prescription refills, reporting greater than 10/10 pain, reporting narcotic prescriptions to be lost or stolen, or requesting medication by name; Grover, Elder, Close, & Curry, 2012). Additionally, many drug-seeking patients will also request

medication by name, request intravenous medication instead of oral forms, and request where they medication is administered (i.e. close to the vein vs. higher up the intravenous tubing; Grover, Close, Wiele, Villarreal, & Goldman). The estimation of the number of drug-seeking patients in the ED is likely a gross underestimation because of the difficulty many providers have in identifying and managing drug-seeking patients (Longo, Parran, Johnson, & Kinsey, 2000).

Opioid pain reliever overdose death rates have soared as sales of opioids have increased (Kuehn, 2007, 2012). There are now more opioid pain reliever deaths than deaths from heroin and cocaine combined (Okie, 2010). Furthermore, in 2008, opioid overdoses surpassed motor vehicle accidents as the number one cause of injury death since 1980 (Warner, Chen, Makuc, 2011). From 1999 to 2010, a 300% increase in sales rates occurred for opioid pain relievers (Mack, Jones, & Paulozzi, 2013). With increasing sales have come increasing rates of drug overdose deaths, as well as chronic nonmedical use of these pain relievers (Jones, Mack, Paulozzi, 2012; Jones, Mack, Paulozzi, 2013).

It is approximated that 2.2-2.4 million people initiate non-medical use of prescription drugs each year (SAMSHA, 2010). Rates of opioid misuse and abuse are highest among men, all people ages 20-64 years old, non-Hispanic Caucasians, and those from poorer socioeconomic statuses and rural areas (Paulozzi & Baldwin, 2012). Other populations at high risk for opioid abuse are those that take high doses of opioid medication and persons with a history of mental illness and other substance abuse problems (Bohnert et al., 2011; Hall et al. 2008). In 2010 alone, 15,323 deaths among women were attributed to drug overdose, with one or more prescriptions involved in 85% of those deaths, with 73% of those being opioid pain relievers (Mack, Jones, & Paulozzi, 2013). Among men there were 23,006 drug overdose deaths and 44% were from opioid pain relievers (Mack, Jones, & Paulozzi, 2013).

Adults are not the only population affected by prescription drug abuse. Recent data suggests that the non-medical prescription drug abuse problem in adolescents is even larger than the abuse of other illicit street drugs, second only to marijuana (SAMHSA, 2011). Getting “high,” pain relief, weight loss, addiction, insomnia, and decreased anxiety are all reasons adolescents have expressed turning to non-medical prescription medication (Boyd, McCabe, Cranford, & Young, 2007). In addition, the use of illicit drugs along with binge drinking have been found to be a strong correlate of non-medical prescription drug use (Ford, 2009; Simoni-Wastila et al., 2004). Adolescents are particularly dangerous population because of the close contact peers have with each other and how easily accessible prescription medication can be exchanged from person to person (McCabe, 2008). The passing of medication frequently has the potential to make it socially acceptable to share medication without the social repercussions that come along with using illicit street drugs.

Based on the National Survey on Drug Use and Health data from 2008 and 2009, individuals obtained pain relievers in a variety of ways. As many as 55% reported getting the prescriptions from a friend or relative, 18% reported they got it from a doctor, 5% got pain relievers from a drug dealer, and 0.4% bought them off the internet (Maxwell, 2011). From these responses, it seems that as much as 73% of the pain relievers abused by Americans were written by a health care provider. Based on these findings, it is important to look to EPs prescribing habits and views of the drug-seeking patient to try and reduce the number of opioid pain reliever prescriptions written.

Prescription drug misuse among youth and young adults has resulted in a number of emergency department visits. For persons aged 12-17, ED visit rates for narcotic pain reliever misuse are 38.4 per 100,000 (SAHSHA, 2013). For persons aged 18-20 years of age, the rate

increases to 157.2 per 100,000 for pain relievers (2013). While persons 21-24 years of age have rates nearly doubled, with 306.2 per 100,000 people seeking emergency treatment for pain reliever misuse. These rates are higher than all other illicit drug use emergency department visits (e.g. heroin, cocaine, stimulants, synthetic cannabinoids) except marijuana (2013).

Emergency room providers (EP) have been criticized in the past for ignoring pain in their patients and were highly encouraged by medical and government organizations to take this symptom more seriously (Todd, 2005; Lembke, 2012). This finding resulted in an increased number of opioids prescribed by emergency room physicians. As much as 60% of the opioids that are abused in the United States are obtained through physicians and many of those physicians are those working within emergency departments (Lembke, 2012). Additionally, many emergency room providers have been required to attend continuing education classes about managing pain (Lembke, 2012).

As many more EPs were taught about the under treatment of pain, increases in opioid prescribing for pain have occurred. From 1993 to 2005 opioid prescribing for pain in the emergency department went up from being prescribed 23% of the time for pain related visits, to 37% of the time for pain related visits (Pletcher, Kertesz, Kohn, & Gonzales, 2008).

Pain management in the hospital setting, has been widely discussed over the past 30 years. Inadequate treatment of pain has led to a variety of healthcare problems, including the development of patients with “pseudoaddiction”. The term pseudoaddiction was first described in 1989 as a condition where patients will mimic the behaviors of drug-seeking patients because of inadequately treated pain (Weissman & Haddox, 1989). This syndrome is the result of care providers undertreating pain, which puts added distress on the patient, creating a hostile environment where both the healthcare provider and the patient suffer (1989). During

pseudoaddiction, patients may show classic signs of the drug-seeking patient, which are described above (Grover, Elder, Close , & Curry, 2012). Once a provider treats the patient's pain with the correct dose of medicine, usually an opioid, patients discontinue all drug-seeking behaviors (2012). Determining validity of pain claims continues to be a challenge of the EP.

While there has been increased research and education to determine how doctors should manage pain, little attention has been paid to the management of prescription drug-addicted patients and the perceptions emergency room physicians have about this class of patients. As early as the late 1990s, emergency departments were piloting programs to better refer patients to substance abuse counseling for prescription drug addiction, but unfortunately this has not become common practice in today's ED (Bernstein, Bernstein, & Levenson, 1997; Macleod & Swanson, 1996).

A variety of factors have contributed to the prescription drug problem we face today. In the early 1990s, a large push was made to aggressively treat non-cancer pain (Hernandez & Nelson, 2010). Change in the attitudes of both EPs and patients have transformed complaints of pain to emergency status (McManus & Harrison, 2005). Furthermore, under treatment of chronic pain has led to pain being classified as the fifth vital sign (Alexander, Kruszewski, & Webster, 2012). In many emergency rooms, patients are asked to rate their pain on a scale of 1-10 upon arrival. One study that described ED nurse's barriers to accurately treating pain identified the 1-10 pain scale as a barrier, explaining that many patients do not understand how to interpret the scale, and subsequently give inaccurate, often times higher, accounts of their pain (Bergman, 2012).

Patient satisfaction surveys also serve as a way for patients to rate EP's performance in the emergency department. Some of the most important areas in which patients rate their visit to

the ED include amount of time waiting, how caring the nurses were, staff organization, and how caring the doctors were, the latter being something that could be biased by the amount of pain medication given (Macleod & Swanson, 1995). A large push was made to make pain management an important part of patient satisfaction surveys. In a 2010 ED study, when at least a 40% reduction of patient pain was reached, doctors received positive reviews in patient satisfaction surveys, while patients that did not experience the same degree of pain relief gave negative reviews of their care by the physician (Downey & Zun, 2010). In many hospitals, patient satisfaction ratings can determine hospital funding and decisions to promote individual health care providers. With so much riding on patient satisfaction, many physicians feel coerced into giving more pain medications than needed to satisfy patients (Lembke, 2012).

Another change occurred when many drug companies began heavily marketing name-brand drugs, such as Oxycontin directly to consumers (Zee, 2009). This drug contains an extended release of hydrocodone, a powerful opioid medication. Additionally, Purdue Pharma recruited 5000 health care providers to attend symposia to help market the drug (GAO, 2003). Initially, the risks of addiction to the drug were misrepresented as being low risk (Zee, 2009). The drug was marketed to treat “nonmalignant” pain, i.e. pain not caused by some form of cancer (Maxwell, 2011). With the trends in health care culture moving towards treating pain and pharmaceutical companies aggressively promoting pain medication, it is not surprising that the rise of prescription pain reliever addiction grew so rapidly.

Many emergency department visits are attributed to the misuse or abuse of opioids. In 2007, over 45% of the emergency room visits associated with drug use were attributed to non-medical use of prescription drugs, a third of these visits included prescription opioids (White, Birnbaum, Rothman, & Katz, 2009). Some of the side effects of opioid pain relievers include

respiratory depression, constipation, nausea, vomiting, confusion, itching, and difficulty with micturition (Cowan, Allan, Griffiths, 2002). These side effects alone involve many of the opiate pain reliever related emergency room visits along with other drug interactions (SAMSHA, 2010). Respiratory depression is one of the most dangerous and lethal side effects of the opiates, leading to hypoxia and or pulmonary edema, and sometimes causing death (White & Irvine, 1999).

To curtail abuse and diversion, certain payer systems have been studied to determine persons at higher risk for prescription drug abuse based on their health service claims. One study used insurance claims data to identify factors associated with high risk of opioid abuse, which included age, complaint of back pain, headaches, and complaints of multiple sources of pain (Edlund, Martin, Fan, Devries, Braden, & Sullivan, 2009). Costs to the healthcare system have been estimated at 72.5 billion annually for private and public healthcare payers (Strassels, 2009). While Medicare and Medicaid fraud have been attributed to a large amount of the costs (Government Accountability Office; GAO, 2009; 2011). Since many health care providers find it difficult to identify drug-seeking patients, many liberally use unneeded diagnostic tools to identify a patient's non-organic pain (Hawkins, Smeeks, & Hamel, 2008). These additional tests contribute to the very high costs of emergency department visits.

Many policies have been developed to control the prescription drug addiction epidemic facing the nation as well as cut costs. Electronic prescription drug monitoring programs (PDMPs) were created in almost every state which contain information such as the patient's name, drug name prescribed, the strength of the medication, the quantity prescribed, the date, and the prescriber (Deyo et al., 2013). Only controlled substances are kept in this database, or drugs with the potential for abuse (2013). Although many states have a program, not all programs are created equal. Only eight states require prescribers to access their state's database

while 41 states have a voluntary prescriber participation program (2013). This means that prescribers are not required to check the database before administering opioid medications to a patient, making it easier for patients to go to multiple providers for medications, also known as “doctor shopping”.

The U.S. General Accounting Office was asked by Congress to study state PDMPs to reduce diversion of prescription drugs. Some studies have looked at the efficacy of PMDPs and whether or not they affect drug abuse or rates. One study reported that there was no significant difference in prescription drug overdose death rates in rates in states with PDMPs versus states without them (Paulozzi, Kilbourne, & Desai, 2011). However, 2012 study found that PDMPs are associated with smaller increases in drug abuse and misuse over time (Reifler et al., 2012).

Pain clinics and “pill mills” have been another source of pain pill abuse and diversion. The term “pill mill” typically describes a pain clinic, doctor, or pharmacy that prescribes or dispenses controlled substances inappropriately or unlawfully (Malbran, 2007). Additionally, these clinics or pharmacies may be run by unlicensed doctors or pharmacists that have a payment policy that requires patients to pay cash only, does not require patients to have physical exams, and allows patients to choose the medicine they would like to purchase (2007). These facilities have made it easier for people to make a profit from selling these drugs on the streets or use them for personal abuse or misuse. Rigg, March, & Inciardi (2010) studied a variety of pain clinics in South Florida where doctors and pharmacists were found to falsify medical records, use old x-rays for diagnosis, and allow patients to purchase unlimited quantities of pain medication. It was discovered that many of these individual doctors running the pain clinics were making upwards of \$30,000 per day in personal profits (2010). With such a large population of pain pill addicted buyers, this illegal market flourishes in the United States.

Many clinicians and researchers have studied behaviors of drug-seeking patients, in order to better identify this patient population. Although research has been done in this area, it proves to be difficult for many clinicians to accurately identify a drug-seeking patient. Many EDs commonly have patients request pain medication to improve maladies including headaches, chronic back pain, abdominal pain, pelvic pain, and dental pain (Macleod & Swanson, 1996). In a 2012 study examining drug-seeking patient's behaviors, patients reporting greater than 10/10 pain was the most common drug-seeking behavior, with patients exhibiting 1.1 drug-seeking behaviors per ED visit (Grover, Elder, Close, & Curry, 2012). Current ED guidelines for pain treatment suggest that if a clinician feels that there is a possibility the patient may be obtaining a narcotic for abuse, they should limit the number of pills prescribed and avoid prescribing notoriously abused opioids, such as Oxycontin (Paris, 2006).

As early as 1996, many emergency departments were identifying drug-seeking patients and working to find systems to handle this patient population (Macleod & Swanson, 1996). Some of the institution-wide strategies that have been employed include not using narcotics to treat headaches, creating contracts with patients that track frequency of visits for opioids, and requiring primary care providers to write letters on the patient's behalf to receive opioids for questionable patients (1996). One ED developed a task force for drug-seeking patients that recorded which patients were frequent visitors of the ED and detailed histories about the patient's behavior, in order to identify common themes in drug-seeking versus oligoanalgesia (Hawkins, Smeeks, Hamel, 2007).

Taverner, Dodding, & White (2000) describe how to teach clinical skills in managing drug-seeking patients in a primary care setting. Some of the content of the teaching session included didactic tutorials, which served to define drugs of addiction, reviewing state regulations

of governing prescription drugs of addiction, distinguishing drug-seeking behaviors, and recognizing signs and symptoms of drug dependence. Once a patient was recognized as being a drug-seeking patient, providers were educated on how to refuse to prescribe medications, prescribing small amounts of medications, giving options of treatment of drug dependence, and understanding that person addicted to drugs is in genuine need of help (Taverner, Dodding, & White, 2000). All of these skills together serve as a comprehensive way to both recognize and manage these patients and may be translatable in the emergency room setting.

Many of the drug-seeking patients that visit the emergency department present as more complex patients with comorbidities such as mental illness, mood disorders, social isolation and homelessness, more chronic painful conditions, as well other substance abuse issues (Lee & Davenport, 2006; Neighbor, Dance, Hawk, & Kohn, 2011). As a result, many of these patients report much higher levels of pain and are more difficult to treat because of their other comorbidities (Neighbor, Dance, Hawk, & Kohn, 2011). This may make it more difficult for EPs to ethically deny their patients pain medication, because they are truly experiencing pain, while not feeding their substance abuse problem.

Another problem emergency departments face relates to overcrowding of emergency department waiting rooms with drug-seeking patients. Since drug-seeking patients are there for one reason, to obtain opioid medications, sometimes they succeed by wearing down tired EPs at the end of their shift. One study focused to develop case management interventions to try and reduce frequency of visits. Lee & Davenport (2006) found that case management interventions were able to reduce visits of patients that frequently use the emergency department by 7.4%, an amount that was not statistically significant, but may be useful to try on a larger sample size.

In a 2003 study, which examined a probability sample of a past ED patient population, found that 27% of their patients were assessed as needing substance abuse treatment (Rockett, Putnam, Jia, & Smith, 2003). This small study alone shows the potential ways in which emergency departments may be used to assess and provide access community members in need of treatment. In the age of electronic medical records, this may become a way of notifying quickly notifying the ED staff of a potential drug-seeking patient.

Some emergency departments have tried to use screening methods to identify prescription drug abuse and offer them referrals to treatment while they are in the health care environment. Identifying drug-seeking patients in the emergency department has gotten mixed reviews in the literature as to whether or not it is effective in reducing drug-seeking behavior (Geiderman, 2003). One program, known as the Screening Brief Intervention, Referral, and Treatment (SBIRT) are being used by many emergency departments across the country (Parker, Librart, Fanning, Higgs, & Dirickson, 2012). This program, as indicated by the name, allows medical professionals to make a quick assessment of patients and offer an intervention, a model that seems perfectly made for the fast-paced speed of the emergency department.

Chapter 3

Methods

With nearly 2.2-2.4 million people initiating use of prescription drugs and thousands of Americans overdosing from opioid drugs each year, it has been declared a public health epidemic in many states, including Ohio. Approximately 18% of Americans that misused prescription medication report that it came from a doctor, many of those emergency room doctors.

Many times, emergency departments in the U.S. are used as clinics for those with little or no insurance due to low socioeconomic statuses and thus at high risk for prescription drug abuse. Based on this information, it is important to examine the beliefs and prescribing behaviors of emergency health care providers in constant contact with these populations in order to reduce the number of potentially abusable prescription drugs coming from these facilities.

The purpose of the present study is to examine emergency department health care provider's perceptions and practices involving the drug-seeking patient in order to better serve this patient population. This study serves to examine how emergency department health care providers prescribe and how they view this frequently cared for patient population.

Chapter one discussed the research questions, hypotheses, operational definitions, delimitations, limitations, and assumptions regarding health care provider perceptions of drug-seeking patients in the ED. Chapter two served to provide a comprehensive review of the literature for the topic. This chapter describes the methods used in this study.

Participants

The participants of the present study included 144 current emergency department staff members who rotate through the hospitals of UC Health: University Hospital, West Chester Hospital, and Jewish Hospital in Cincinnati. The emergency department staff is all considered part of one institution. Participants were recruited via email. Email lists were obtained from ED administration at the University Hospital of Cincinnati. All participation in the study was voluntary and no incentives were offered.

Instrumentation

Based on a comprehensive review of the professional literature and individual discussions with emergency department physicians, resident physicians, mid-level providers, nurses, substance abuse researchers, and survey experts, a four-page, 67-item survey (Appendix B) was developed to examine health professionals' attitudes and beliefs about drug-seeking patients in the ED and how they prescribe to them. Additionally, content validity of the instrument was established by means of a panel of five experts: two substance abuse researchers and health education specialists along with three emergency department physicians with expertise in the areas of survey design, survey research, and emergency department procedures. Each member of the panel was emailed a copy of the survey and instructed to complete the survey and offer comments or suggestions regarding the instrument and its scoring system. Recommendations from the experts were incorporated into the final survey instrument.

The survey was divided into six sections. The first section of the survey asked participants to rate how much they agreed or disagreed with varying statements about drug-seeking patients and their own practices. A five-point likert scale was used to score results.

Responses of strongly disagree, disagree, neutral, agree, and strongly agree were possible and scores ranged from 1 to 5 respectively. This section had 25 items and asked participants a variety of questions about drug-seeking patients. The first theme included their ability to recognize a patient, prevent drug-seeking patients from obtaining opioids from the ED, assist in helping them in getting treatment for their condition, or assist drug-seeking patients in seeing a counselor. The second theme included their views on pain control and treating pain as a drug-seeking problem. The third theme asked their views on the importance of decreasing the number of potentially abusable drugs, screening patients for substance abuse, and decreasing the number of narcotics prescribed. The fourth theme asked participants views on various policies in the ED regarding drug-seeking patients, including current protocols to manage drug-seeking behavior, referring patients to mental health professionals, and views on The Joint Commission. The last theme discussed addresses participant's behaviors when dealing with a combative drug-seeking patient and how their behavior changes based on patient performance reviews, which affect staff salary and future promotions.

The second section addresses participant's behavior in response to drug-seeking patients based on how likely it is for them to perform a behavior. Staff members were asked "How likely is it for you to...?" with four questions following. The questions included answers to how likely it is for a staff member to suggest a referral for a patient demonstrating drug-seeking behavior to a social worker or mental health facility, suggesting an intervention (i.e. drug rehabilitation, counseling etc.), suggest a patient demonstrating drug-seeking behavior talk to a social worker, or confront a patient exhibiting drug-seeking behavior about their potential addiction. Participants responded with a four-point likert scale. Potential responses were not likely, slightly likely, moderately likely, and extremely likely and scores ranged from 1 to 4, respectively.

The third section assessed barriers to helping drug-seeking patients with their drug abuse problem and affect prevention of drug-seeking behavior in the emergency department. The first question provided 10 barriers that prevented health care professionals from helping drug-seeking patients with their drug abuse problem and to check all that apply. An “other” category was also included. Each checked barrier received a score of 1, while each unchecked barrier received a score of 0, resulting in an overall potential range of 0 to 11. The second question asked “How can we effectively prevent patients from drug-seeking in the emergency department” and 12 prevention strategies were listed. Participants were asked to check all that apply. An “other” category was also included. Each checked barrier received a score of 1, while each unchecked barrier received a score of 0, resulting in an overall potential range of 0 to 13.

The fourth section asked participants to rate how often they performed certain behaviors regarding their prescribing habits. A six-point likert scale was used with the following options for responding to how often the participants perform certain behaviors: Never (0%), Rarely (1%-25%), Sometimes (26%-50%), Most of the time (51%-75%), Almost always (76%-99%), and Always (100%). The responses were scored from 1 to 6, respectively. Examples of the type of questions asked included how often EPs screen patients for drug abuse, refer know drug abusers to a counselor, follow state recommendations for prescribing pain medication, talk to a patient about potential of abuse for pain medications, and treat chronic pain. A detailed list of questions from this section can be found in Appendix B.

The fifth section of the survey asked a series of yes/no questions relating to how health care providers manage pain and prescribe narcotics in the ED. Themes involved in this section of the survey included what types of drugs health care providers use to treat pain, what types of conditions narcotic prescriptions are reserved for, what level of pain necessitates the prescription

of narcotics, and how health care providers feel about prescribing norms and protocols in their ED. A detailed list of the questions can be found in Appendix B.

The sixth section of the survey asked participants to check all that applied to the question “Which of the following sources would you used (now or if they were available) to get information on how to effectively treat drug-seeking patients). Each checked option scored a 1, which unchecked options scored a 0, with an overall potential range of 0 to 8. An “other” category was included with an option to explain.

The seventh section of the survey asked participants to provide demographic and background information about themselves. This section included nine items: gender, title, number of years in current position, race/ethnicity, highest degree received, hospital location description, as well as a question as whether they had a family member with a drug addiction. The final item asked participants to use the space provided to list or discuss any additional thoughts they had on the drug-seeking problem as it related the their profession.

Procedures

The proposal of the study, cover letter to participants, and survey instrument were approved by the researcher’s thesis committee and submitted to the University of Cincinnati Institutional Review Board (IRB). The study was approved by the IRB.

The primary researcher obtained a list of ED faculty and staff email lists from the ED research coordinator. Only attending physicians, resident physicians, physician’s assistants, and nurse practitioners were considered for the study. The researcher sent out a REDcap email to all participants with a cover letter explaining the purpose of the study. When participants opened the link to the survey, a research information sheet was included as the first page of the survey

(Appendix A). Participants were informed of the study purpose, the voluntary nature of the study, and that all responses would be anonymous and confidential. After reading the research information sheet, participants could choose to begin the survey. A total of 144 surveys were sent out to the University of Cincinnati ED faculty and staff. Of those surveys sent out, a total of 85 surveys were completed by the participants.

An attending physician, resident physician, and physician's assistant were recruited to send out additional emails to all research participants on behalf of the primary researcher to show support of the project. These faculty and staff members did not answer questions about the study or interact with the participants.

A second email message was sent to participants that had not responded to the initial emailed survey one week later. All participants were able to complete the survey only once. To obtain consent, the following statement was included in the research information sheet on REDCap: "By submitting your completed survey you indicate your consent for your answers to be used in this research study". At the end of survey completion, all participants had the option of submitting the survey.

All participants were sent a unique link to their email, but the email was not linked to their response. The researcher was only given a list of emails and the emails were not linked to faculty and staff names, keeping the survey both anonymous and confidential. All survey responses were recorded in REDcap, a secure database, with only the primary researcher having access to the completed surveys. The data from the surveys was downloaded and shared with the researcher's committee members. None of the surveys or data contained any identifying information to link the participant response with their emails. The downloaded data was kept on the computers of the research team.

Data Analysis

All data were analyzed using the Statistical Package for the Social Sciences (SPSS Version 16). Descriptive statistics (frequencies, means, standard deviations, ranges) were used to describe the demographic and background information. A series of one-way analyses of variance (ANOVAs) were computed to determine whether the number of barriers associated with helping drug-seeking patients in the ED with their drug abuse problem varied based on the ED professional's sex, title, or years in their current position. Additionally, ANOVAs were computed to examine whether the frequency in which ED professionals follow drug-seeking patient protocol varied based on sex, title, and years in current position. Multivariate analyses of variance (MANOVAs) were conducted to determine whether the confidence ED professionals have in identifying a drug-seeking patient varied based on sex, title, and years in current position. Similarly, MANOVAs were computed to determine whether the importance ED professionals placed on identifying a drug-seeking patient varied based on sex, title, and years in current position. An alpha level of .05 was established for determining significance.

Chapter 4

Results

The purpose of this study was to examine emergency department (ED) health care providers perceptions and practices regarding the drug-seeking patient in order to better serve this patient population. This study serves to examine how emergency department health care providers prescribe and how they view this frequently cared for patient population. The study served to examine the relationships between how health care providers cared for drug-seeking patients based on sex, discipline, and numbers of years worked in their current profession.

Chapter one provided an introduction, discussed the research questions, hypotheses, delimitations, limitations, assumptions, and operational definitions. Chapter two provided a comprehensive review of the literature and Chapter three discussed the methods used in this study. This chapter discusses the research results.

Participation

Emergency department health care providers (n=85), including attending physicians, resident physicians, physician's assistants, and nurse practitioners at a Midwestern university-based hospital served as participants in the study. A total of 144 surveys were emailed out and 85 completed, resulting in a response rate of 59.0%. No surveys were incomplete, resulting in a total sample size of 85 participants and a total participation rate of 59.0%.

Demographic and Background Characteristics

The majority of participants were male (69.4%) and white (93.9%) (Table 4.1). Titles of participants included attending physicians (43.5%), resident physicians (35.6%), physician's assistants (14.1%), nurse practitioners (5.9%), and other (1.2%). Employment in current position ranged from half a year to 40 years.

Table 4.1 Demographic and Background Characteristics of Participants

Characteristic	<i>n</i>	%
Sex		
Male	59	69.4
Female	26	30.6
Title		
Attending Physician	37	43.5
Resident	30	35.6
Physician's Assistant	12	14.1
Nurse Practitioner	5	5.9
Other	1	1.2
Race/Ethnicity		
African American	2	2.4
Asian	1	1.2
Caucasian	77	93.9
Hispanic	1	1.2
Multiracial	1	1.2

N=85; Percents refer to valid percents; Missing values excluded

Barriers to Helping the Drug-seeking Patient with Their Drug-abuse Problem

Participants were asked to determine the barriers in their workplace that prevent them from helping drug-seeking patients with their drug abuse problem in the emergency room. A list of 10 barriers plus an option for “other” were provided for participants to check all barriers that applied. The top three barriers reported were lack of treatment available for the patient (83.5%), patient refusal to get help (81.2%), lack of available drug abuse counseling staff in the ED (74.1%). The three least reported barriers were lack of support from ED administration (12.9%), lack of support from ED colleagues (9.4%), and “other” (7.1%) (Table 4.2).

An ANOVA was conducted to examine the number of perceived barriers health care providers chose based on sex (Table 4.3). Results indicated that there were no significant differences in barriers between males ($M = 4.72$, $SD = 1.720$) and females ($M = 4.38$, $SD = 1.961$), $F(1, 85) = .663$, $p = .418$.

An ANOVA was conducted to examine the number of perceived barriers health care providers chose based on title (Table 4.3). Title was dichotomized into two categories: attending physicians and “other”. The “other” category included titles of resident physicians, physician’s assistants, and nurse practitioners. Results indicated that there were no significant differences in barriers between attending physicians ($M = 4.76$, $SD = 1.877$) and other professionals ($M = 4.53$, $SD = 1.755$), $F(1, 85) = .320$, $p = .573$.

An ANOVA was conducted to examine the number of perceived barriers health care providers chose based on years in current position (Table 4.3). Years in current position was dichotomized into two categories: 1-4 years and 5-40 years. Results indicated that there were no significant differences in barriers between professionals with 1-4 years in their current position

($M = 4.72$, $SD = 1.720$) and professionals with 5-40 years in their current position ($M = 4.38$, $SD = 1.961$), $F(1, 85) = .663$, $p = .418$.

Table 4.2 Barriers that prevent healthcare professionals from helping drug-seeking patients with their drug abuse problem

Barriers	<i>n</i>	%
Fear of administrative repercussion for not prescribing narcotics		
Unchecked	71	83.5
Checked	14	16.5
Not knowing how to help drug-addicted patients		
Unchecked	47	55.3
Checked	38	44.7
Lack of treatment available for the patient		
Unchecked	14	16.5
Checked	71	83.5
Lack of available drug abuse counseling staff in the ED		
Unchecked	22	25.9
Checked	63	74.1
Lack of professional training to help drug-addicted patients		
Unchecked	55	64.7
Checked	30	35.3
High cost of drug abuse treatment for the patient		
Unchecked	46	54.1
Checked	39	45.9
Patients lack health insurance to pay for treatment		
Unchecked	27	31.8
Checked	58	68.2
Lack of support from ED administration		
Unchecked	74	87.1
Checked	11	12.9
Lack of support from ED colleagues		
Unchecked	77	90.6
Checked	8	9.4
Patient refusal to get help		
Unchecked	16	18.8
Checked	69	81.2
Other		
Unchecked	79	92.9
Checked	6	7.1

N=85; Percents refer to valid percents; Missing values excluded

Table 4.3 Number of perceived barriers in helping ED patients with their drug abuse problem based on sex, title, and years in current profession

Independent Variable	Number of Perceived Barriers <i>M</i> (SD)	<i>F</i>	<i>p</i>
Sex			
Male	4.73 (1.720)	.663	.418
Female	4.38 (1.961)		
Title			
Attending Physician	4.76 (1.877)	.320	.573
Other	4.53 (1.755)		
Years in Current Position			
1 to 4	4.80 (1.720)	.755	.235
5 to 40	4.606 (1.886)		

N = 85; Range = 0-11 barriers; Missing values excluded

Frequency in Which Health Care Providers Follow Drug-seeking Patient Protocol

Participants were asked to respond to the question “how often do you follow drug-seeking patient protocol based on a six-point scale (Table 4.4). Approximately one in four (24.7%) participants reported “almost always” following the drug-seeking patient protocol. Only 2.4% of participants always followed the ED’s drug-seeking patient protocol whereas 17.6% of participants never followed drug-seeking patient protocols.

An ANOVA was conducted to determine if following ED drug-seeking patient protocols differed based on sex (Table 4.5). Results indicated that there were no significant differences in frequency of following ED drug-seeking patient protocols between males ($M = 3.23$, $SD = 1.476$) and females ($M = 3.63$, $SD = 1.630$), $F(1, 85) = .130$, $p = .719$.

An ANOVA was conducted to determine if following ED drug-seeking patient protocols differed based on title (Table 4.5). Title was dichotomized into two categories: attending physicians and “other”. The “other” category included resident physicians, physician’s assistants, and nurse practitioners. Results indicated that there were no significant differences in frequency of following ED drug-seeking patient protocols between attending physicians ($M = 3.14$, $SD = 1.574$) and other professionals ($M = 3.35$, $SD = 1.494$), $F(1, 85) = .357$, $p = .552$.

An ANOVA was conducted to determine if following ED drug-seeking patient protocols differed based on years in current position (Table 4.5). Years in current position was dichotomized into two categories: 1-4 years and 5-40 years. Results indicated that there were no significant differences in frequency of following ED drug-seeking patient protocols between professionals with 1-4 years in their current position ($M = 3.20$, $SD = 1.472$) and professionals with 5-40 years in their current position ($M = 3.22$, $SD = 1.560$), $F(1, 85) = .002$, $p = .968$.

Table 4.4 ED Provider's prescribing and care behaviors

Do you...	<i>n</i>	%
Follow ED drug-seeking patient protocol?		
Never (0%)	15	17.6
Rarely (1%-25%)	13	15.3
Sometimes (26%-50%)	14	16.5
Most of the time (51%-75%)	17	20.0
Almost always (76%-99%)	21	24.7
Always (100%)	2	2.4

N=85; Percents refer to valid percents; Missing values excluded

Table 4.5 Frequency in which ED professionals follow drug-seeking patient protocol based on sex, title, and years in current profession

Independent Variable	<i>M</i> (SD)	<i>F</i>	<i>p</i>
Sex			
Male	3.23 (1.476)	.130	.719
Female	3.36 (1.630)		
Title			
Attending Physician	3.14 (1.574)	.357	.552
Other	3.35 (1.494)		
Years in Current Position			
1 to 4	3.20 (1.472)	.002	.968
5 to 40	3.22 (1.560)		

N=85; Means based on a 6-point scale (1= Never (0%); 2= Rarely (1%-25%); 3= Sometimes (26%-50%); 4= Most of the time (51%-75%); 5= Almost always (76%-99%); 6= Always (100%).

Confidence ED Professionals Have in Identifying the Drug-seeking Patient

Participants were asked to respond to four questions regarding their confidence in identifying the drug-seeking patient. Participant responses were based on a five-point scale (1= Strongly Disagree; 2= Disagree; 3= Neutral; 4= Agree; 5= Strongly Agree). A MANOVA was conducted to determine if participant responses to each of the four questions differed based on sex (Table 4.6). No significant differences were found based on sex $F(4, 85) = .576, p = .681$.

A MANOVA was conducted to determine if participant responses to each of the four questions differed based on title (Table 4.7). No significant differences were found based on title $F(4, 85) = .199, p = .938$.

A MANOVA was conducted to determine if participant responses to each of the four questions differed based on years in current profession (Table 4.8). No significant differences were found based on years in current position $F(4, 85) = 2.450, p = .053$. Following univariate F tests, the first question, revealed that there was a significant difference between providers with 1-4 years of experience and providers with 5-40 years of experience. There were no significant differences following univariate F tests for the remaining questions.

Table 4.6 Confidence ED professionals have in identifying a drug-seeking patient based on sex

Item	Male <i>M</i> (SD)	Female <i>M</i> (SD)	<i>F</i>	<i>P</i>
I feel confident I can recognize if a patient is drug-seeking.	3.32 (.880)	3.42 (.902)	.234	.630
I feel confident I can effectively prevent patients from obtaining prescription drugs for abuse from the ED.	2.86 (.955)	2.85 (1.047)	.006	.937
I feel confident to deny pain medication to patients I do not feel require it for their medical condition.	3.86 (.899)	4.08 (.628)	1.192	.278
I feel confident I can convince a patient experiencing drug-seeking behaviors to see a counselor.	1.93 (.828)	2.04 (.824)	.298	.586

N=85; Means based on a 5-point scale (1= Strongly Disagree; 2= Disagree; 3= Neutral; 4= Agree; 5= Strongly Agree)

Table 4.7 Confidence ED professionals have in identifying a drug-seeking patient based on title

Item	Attending Physician <i>M</i> (<i>SD</i>)	Other <i>M</i> (<i>SD</i>)	<i>F</i>	<i>p</i>
I feel confident I can recognize if a patient is drug-seeking.	3.27 (.932)	3.40 (.851)	.472	.494
I feel confident I can effectively prevent patients from obtaining prescription drugs for abuse from the ED.	2.84 (.898)	2.89 (1.047)	.066	.797
I feel confident to deny pain medication to patients I do not feel require it for their medical condition.	3.89 (.809)	3.98 (.847)	.226	.636
I feel confident I can convince a patient experiencing drug-seeking behaviors to see a counselor.	1.92 (.924)	1.98 (.737)	.109	.742

N=85; Means based on a 5-point scale (1= Strongly Disagree; 5= Strongly Agree)

Table 4.8 Confidence ED professionals have in identifying a drug-seeking patient based on years in current position

Item	1-4 years <i>M</i> (SD)	5-40 years <i>M</i> (SD)	<i>F</i>	<i>p</i>
I feel confident I can recognize if a patient is drug-seeking.	3.09 (.915)	3.67 (.692)	9.384	.003
I feel confident I can effectively prevent patients from obtaining prescription drugs for abuse from the ED.	2.72 (1.004)	3.00 (.935)	1.612	.208
I feel confident to deny pain medication to patients I do not feel require it for their medical condition.	3.87 (.859)	3.94 (.788)	.136	.713
I feel confident I can convince a patient experiencing drug-seeking behaviors to see a counselor.	1.96 (.650)	1.79 (.650)	.969	.328
N= 85; Range = 0.5 years – 40 years; Means based on a 5-point scale (1= Strongly Disagree; 5= Strongly Agree)				

Importance of Identifying a Drug-seeking Patient in the ED

Participants were asked to respond to three questions regarding their perceived importance of identifying the drug-seeking patient. Participant responses were based on a five-point scale (1= Strongly Disagree; 2= Disagree; 3= Neutral; 4= Agree; 5= Strongly Agree). A MANOVA was conducted to determine if participant responses to each of the three questions differed based on sex (Table 4.9). No significant differences were found based on sex $F(3, 85) = .634, p = .595$.

A MANOVA was conducted to determine if participant responses to each of the three questions differed based on title (Table 4.10). No significant differences were found based on title. Following univariate F tests, the first question showed a significant difference between attending physicians and other health care professionals. There were no significant differences following univariate F tests for the remaining questions.

A MANOVA was conducted to determine if participant responses to each of the three questions differed based on years in their current position (Table 4.11). No significant differences were found based on years in current position $F(3, 85) = 2.538, p = .063$. Following univariate F tests, the first question showed a significant difference between providers with 1-4 years of experience and providers with 5-40 years of experience. There were no significant differences following univariate F tests for the remaining questions.

Table 4.9 ED professional's perceived importance of identifying a drug-seeking patient based on sex

Item	Male <i>M</i> (SD)	Female <i>M</i> (SD)	<i>F</i>	<i>p</i>
I feel that it is important to talk to all patients in the ED about the abuse potential of drugs they are being prescribed (i.e. narcotics, benzodiazapines, muscle relaxers, antiemetics, etc.).	3.71 (.899)	3.73 (1.041)	.011	.915
I feel that it is important for my ED to have a policy to decrease drugs prescribed to potential drug-seeking patients.	4.14 (.868)	4.38 (.637)	1.689	.197
I feel that it is important for me to screen patients for substance abuse in the ED.	3.53 (.977)	3.50 (.960)	.023	.879

N= 85; Means based on a 5-point scale (1= Strongly Disagree; 5= Strongly Agree)

Table 4.10 ED professional's perceived importance of identifying a drug-seeking patient based on title

Item	Attending Physician <i>M</i> (SD)	Other <i>M</i> (SD)	<i>F</i>	<i>p</i>
I feel that it is important to talk to all patients in the ED about the abuse potential of drugs they are being prescribed (i.e. narcotics, benzodiazapines, muscle relaxers, antiemetics, etc.).	3.47 (.878)	3.94 (.919)	5.403	.023
I feel that it is important for my ED to have a policy to decrease drugs prescribed to potential drug-seeking patients.	4.08 (.906)	4.30 (.720)	1.445	.233
I feel that it is important for me to screen patients for substance abuse in the ED.	3.47 (1.108)	3.57 (.827)	.232	.631

N=85; Means based on a 5-point scale (1= Strongly Disagree; 5= Strongly Agree)

Table 4.11 ED professional's perceived importance of identifying a drug-seeking patient based on years in current position

Item	1-4 years <i>M</i> (SD)	5-40 years <i>M</i> (SD)	<i>F</i>	<i>p</i>
I feel that it is important to talk to all patients in the ED about the abuse potential of drugs they are being prescribed (i.e. narcotics, benzodiazapines, muscle relaxers, antiemetics, etc.).	3.91 (.839)	3.41 (.979)	6.002	.017
I feel that it is important for my ED to have a policy to decrease drugs prescribed to potential drug-seeking patients.	4.33 (.762)	4.06 (.878)	1.994	.162
I feel that it is important for me to screen patients for substance abuse in the ED.	3.59 (.933)	3.34 (1.004)	1.206	.276

N=85; Range = 0.5 years – 40 years; Means based on a 5-point scale (1= Strongly Disagree; 5= Strongly Agree)

Hypothesis Testing

Null hypothesis 1. There will be no significant differences in health professionals' confidence in identifying a drug-seeking patient based on sex.

A MANOVA was conducted to determine if confidence in identifying the drug-seeking patient differed based on sex. Results showed that there was no significant difference in confidence in identifying the drug-seeking patient between males and females, $F(4, 85) = .576, p = .681$. Therefore, the null hypothesis was not rejected.

Null hypothesis 2. There will be no significant differences in health professionals' confidence in identifying a drug-seeking patient based on title.

A MANOVA was conducted to determine if confidence in identifying the drug-seeking patient differed based on title. Results were dichotomized into two categories: attending physicians and "other". The "other" category was comprised of resident physicians, physician's assistants, and nurse practitioners. Results showed that there was no significant difference in confidence in identifying the drug-seeking patient between attending physicians and other titles, $F(4, 85) = .199, p = .938$. Therefore, the null hypothesis was not rejected.

Null hypothesis 3. There will be no significant differences in health professionals' confidence in identifying a drug-seeking patient based on years in current position.

A MANOVA was conducted to determine if confidence in identifying the drug-seeking patient differed based on years in current profession. Results were dichotomized into two categories: 1 to 4 years in current position and 5 to 40 years in current position. Results showed that there was no significant difference in confidence of identifying the drug-seeking patient between attending physicians and other titles, $F(4, 85) = 2.450, p = .053$. Therefore, the null hypothesis was not rejected.

Null hypothesis 4. There will be no differences in perceived importance of identifying a drug-seeking patient based on sex.

A MANOVA was conducted to determine if perceived importance of identifying the drug-seeking patient differed based on sex. Results showed that there was no significant difference in importance of identifying the drug-seeking patient between males and females, $F(3, 85) = .634, p = .595$. Therefore, the null hypothesis was not rejected.

Null hypothesis 5. There will be no differences in perceived importance of identifying a drug-seeking patient based on title.

A MANOVA was conducted to determine if perceived importance of identifying the drug-seeking patient differed based on title. Results were dichotomized into two categories: attending physicians and “other”. The “other” category was comprised of resident physicians, physician’s assistants, and nurse practitioners. Results showed that there was no significant difference in importance of identifying the drug-seeking patient between attending physicians and other titles, $F(3, 85) = 2.318, p = .082$. Therefore, the null hypothesis was not rejected.

Null hypothesis 6. There will be no differences in perceived importance of identifying a drug-seeking patient based on years in current position.

A MANOVA was conducted to determine if importance of identifying the drug-seeking patient differed based on years in current profession. Results were dichotomized into two categories: 1 to 4 years in current position and 5 to 40 years in current position. Results showed that there was no significant difference in importance of identification of the drug-seeking patient between professionals with 1-4 years in their current position and 5-40 years in their current position, $F(3, 85) = 2.538, p = .063$. Therefore, the null hypothesis was not rejected.

Null hypothesis 7. There will be no difference in frequency of identifying a drug-seeking

patient based on sex.

An ANOVA was conducted to examine frequency of identifying a drug-seeking patient in the ED based on sex. There was no significant difference between males ($M = 3.23$, $SD = 1.476$) and females ($M = 3.36$, $SD = 1.630$), $F(1, 85) = .130$, $p = .719$. Therefore, the null hypothesis was not rejected.

Null hypothesis 8. There will be no difference in frequency of identifying a drug-seeking patient based on title.

An ANOVA was conducted to examine frequency of identifying a drug-seeking patient in the ED based on title. Results were dichotomized into two categories: attending physicians and “other”. The “other” category was comprised of resident physicians, physician’s assistants, and nurse practitioners. Results showed that there was no significant difference in the frequency of identifying the drug-seeking patient between attending physicians ($M = 3.14$, $SD = 1.574$) and other titles ($M = 3.35$, $SD = 1.494$), $F(1, 85) = .357$, $p = .552$. Therefore, the null hypothesis was not rejected.

Null hypothesis 9. There will be no difference in frequency of identifying a drug-seeking patient based on years in current position.

An ANOVA was conducted to examine frequency of identifying a drug-seeking patient in the ED based on years in current profession. Results were dichotomized into two categories: 1 to 4 years in current position and 5 to 40 years in current position. Results showed that there was no significant difference in frequency of identifying the drug-seeking patient between professionals with 1-4 years in their current position ($M = 3.20$, $SD = 1.494$) and 5-40 years in their current position ($M = 3.22$, $SD = 1.560$), $F(1, 85) = .002$, $p = .986$. Therefore, the null hypothesis was not rejected.

Null hypothesis 10. There will be no difference in the number of barriers to identifying a drug-seeking patient based on sex.

An ANOVA was conducted to examine whether the perceived number of barriers to helping the drug-seeking patient with their drug abuse problem in the ED differed based on sex. Results showed that there was no significant difference in the number of barriers to helping the drug-seeking patient with their drug abuse problem between males ($M = 4.73$, $SD = 1.720$) and females ($M = 4.38$, $SD = 1.961$), $F(1, 85) = .663$, $p = .418$. Therefore, the null hypothesis was not rejected.

Null hypothesis 11. There will be no difference in the number of barriers to identifying a drug-seeking patient based on title.

An ANOVA was conducted to examine whether the perceived number of barriers to helping the drug-seeking patient with their drug abuse problem in the ED differed based on title. Results were dichotomized into two categories: attending physicians and “other”. The “other” category was comprised of resident physicians, physician’s assistants, and nurse practitioners. Results showed that there was no significant difference in the number of barriers to helping the drug-seeking patient with their drug abuse problem between attending physicians ($M = 4.76$, $SD = 1.877$) and other titles ($M = 4.53$, $SD = 1.755$), $F(1, 85) = .320$, $p = .573$. Therefore, the null hypothesis was not rejected.

Null hypothesis 12. There will be no difference in the number of barriers to identifying a drug-seeking patient based on years in current position.

An ANOVA was conducted to examine whether the perceived number of barriers to helping the drug-seeking patient with their drug abuse problem in the ED differed based on years in current profession. Results were dichotomized into two categories: 1 to 4 years in current

position and 5 to 40 years in current position. Results showed that there was no significant difference in the number of barriers to helping the drug-seeking patient with their drug abuse problem between professionals with 1-4 years in their current position ($M = 4.80$ $SD = 1.720$) and 5-40 years in their current position ($M = 4.606$, $SD = 1.886$), $F(1, 85) = .755$ $p = .235$. Therefore, the null hypothesis was not rejected.

Chapter 5

Discussion

Prescription drug overdose morbidities and mortalities have risen steadily over the last 20 years. Today, prescription drug overdose is the most common causes of accidental death in the United States, surpassing motor vehicle accidents (CDC, 2011). Although the most common source of prescription medication is from a friend or family member, it has been found that the friends and family members have obtained their drugs from one or more doctors.

The emergency department has become a source of pain medication for the drug-seeking patient. Many patients feign maladies to obtain prescription drugs for their own misuse and abuse, or to sell illegally for a profit. Currently, many emergency rooms have begun studies examining the behaviors and systems that may reduce the number of drug-seeking patients to decrease frequent emergency department visits and lower rates of prescription drug abuse.

After a thorough review of the literature, there were currently no studies, which examined emergency department care provider's perceptions of the drug-seeking patient. The purpose of this study was to examine how care provider's view and treat the drug-seeking patient by looking at the confidence providers have in identifying the drug-seeking patient, their perceived importance of identifying the drug-seeking patient, the frequency in which they help drug-seeking patients with their drug abuse problem, and barriers to helping the drug-seeking patient with their drug abuse problem.

Chapter one discussed the research questions, hypotheses, delimitations, limitations, assumptions, and operational definitions. Chapter two provided a comprehensive review of the literature. Chapter three discussed the participants, instrumentation, procedures, and data analysis. Chapter four provided the results of this study. This chapter presents the conclusions

from the study, a discussion of the results, and recommendations for improving this research and emergency department practice regarding the drug-seeking patient.

Conclusions

A total of 85 health care providers in the emergency department completed the survey for the present study. The majority of participants were male (69.4%) and white (93.9%) and attending physicians (43.5%). Participant's years in current position ranged from 0.5 years to 40 years.

When examining barriers health care providers encounter to helping drug-seeking patients in the ED, there were no significant differences between the numbers of barriers reported based on sex, title, or years in current position. It was concluded that sex, title, and years in current position had no effect on the perceived number of barriers health care providers reported to helping drug-seeking patients with their drug abuse problem.

The present study showed when examining the frequency in which health care providers follow drug-seeking patient protocol, there was no significant difference based on sex, title, or years in current position. It was concluded that sex, title, and years in current position had no effect on the frequency in which health care providers follow drug-seeking patient protocol.

When examining ED professional's confidence in identifying the drug-seeking patient, there was no significant difference in confidence based on sex, title, and years in current position. It was concluded that sex, title, and years in current position had no effect on health care provider's confidence in identifying the drug-seeking patient.

Finally, the present study found when examining the ED professional's perceived importance of identifying the drug-seeking patient, there were no significant differences based on sex, title, or years in current position. It was concluded that sex, title, and years in current

position had no effect on the perceived importance ED health care providers placed on identifying the drug-seeking patient.

Discussion

Everyday in emergency departments all over the United States, persons addicted to prescription painkillers come to emergency rooms to seek narcotics for feigned maladies. One emergency room that sees 75,000 patients annually, estimated that 262 patients per month are said to be exhibiting drug-seeking behavior (Hansen, 2005). This figure is most likely largely underrepresented, as many clinicians have reported that it is difficult to determine if a patient is truly drug-seeking. Along with the thousands of visits each year of patients drug-seeking, is the equally high occurrence of 475,000 emergency room visits due to prescription drug misuse and abuse (SAMSHA, 2011). As prescription drug overdose has become the number one cause of accidental death of Americans, this has become a disease of epidemic proportions, and in some American cities and counties, a public health emergency. Since many drugs abused by drug-seeking patients are obtained from one or more doctors, it is important to look to doctors and other health care providers with prescribing abilities to determine why so many drugs are being deferred for abuse.

The present study served to examine emergency department health care provider's perceptions of drug-seeking patients to determine ways to reduce the number of drugs deferred, the number of emergency room visits from drug-seeking patients, and to ultimately reduce the number of morbidities and mortalities caused by prescription drugs. Although the present study's null hypotheses regarding differences and beliefs based on sex, title, and years in current position were all not rejected, it is worth looking at the results of the emergency department

studied in more depth to determine changes in prescribing that can be made by the emergency department as whole.

When examining barriers health care providers encounter to helping drug-seeking patients in the ED, participants reported an average of 4.62 (SD = 1.792) barriers. The three highest barriers reported by participants were lack of treatment available for the patient (83.5%), patient refusal to get help (81.2%), and lack of available drug abuse counseling staff in the ED (74.1%), while the three lowest reported barriers were lack of support from ED administration (12.9%), lack of support from ED colleagues (9.4%), and “other” (7.1%). Lack of available treatment is a huge problem in the United States.

One emergency department looked for ways to improve access to primary care services for patients with substance abuse problems in the ED using a program called Project ASSERT (Alcohol Substance Abuse Services and Educating providers to Refer patients to Treatment), a program for improving access to substance abuse services through the ED (Bernstein, Bernstein, & Levenson, 1997). Interestingly, the study found a decrease in harmful behaviors during post enrollment follow-up for patients that were compliant in the program (Bernstein, Bernstein, & Levenson, 1997). This study shows the importance of health education and promotion in the ED and that services can be appropriate when they are modified to work within an ED.

The present study showed when examining the frequency in which health care providers follow drug-seeking patient protocol, more than half (52.9%) of participants reported that they do not follow their ED’s drug-seeking patient protocol more than 50% of the time. Additionally, frequency in following drug-seeking patient protocol did not differ significantly based on sex, title, or years in current position. Although policies are put into place to guide clinical decision-making, it is ultimately the clinician that has the final say in how to treat the patient. One reason

there may be a spread in the way that question was answered could be due to a lack of a fully developed pain policy that is accepted by all members of the ED. One study showed that a united front in how to treat pain in the ED had a success in reducing the numbers of drug-seeking patients in the ED (Taverner, Dodding, & White, 2000). Providing all clinicians with a clear plan on how to treat different types of pain may be effective in reducing the number of opioid medications prescribed in the ED.

When examining ED professional's confidence in identifying the drug-seeking patient, there was no significant difference in confidence based on sex, title, and years in current position. Additionally, on average the participants indicated a "neutral" response on the likert scale, indicating that they were not truly confident in identifying drug-seeking patients.

Interestingly, when univariate F tests were run based on years in current position, those clinicians with 5-40 years in their current position reported a significantly higher confidence in identifying the drug-seeking patient. This result could suggest that more experience is needed to identify drug-seeking patients and that more experienced clinicians may be valuable as teachers to clinicians just beginning their career. Grover, Elder, Close, & Curry (2012) examined the frequency of "classic" drug-seeking behaviors in the ED. They found that there is a pattern of behavior drug-seeking patients exhibit with the four most common chief complaints being patients of reporting 10/10 pain, complaint of headache, complaint of backache, and requesting medication by name. Most clinicians learn to recognize these behaviors after years of experience, but discussing these behaviors at the start of clinician's' careers may reduce the number of drug-seeking patients that receive medication.

Finally, the present study found when examining the ED professional's perceived importance of identifying the drug-seeking patient, there were no significant differences based

on sex, title, or years in current position. Following univariate F tests, it was revealed that when asked directly how important they felt about talking to their patients about the abuse potential of drugs that are being prescribed, “other” professionals (i.e. those that are not attending physicians), in comparison with attending physicians felt it was significantly more important to talk to their patients about abuse potential of drugs. Additionally, persons with 1-4 years of experience felt it was significantly more important to talk to their patients about the abuse potential of drugs they are being prescribed than those with 5-40 years of experience. This result could be due to a variety of factors. One explanation is that persons with more experience become desensitized to the potential dangers in prescribing schedule II (i.e medications with the potential for abuse) medications.

Another explanation of these results could be the United States cultural tendency to treat pain in the ED before looking to reduce addiction. In the early 1990s, emergency departments were criticized for not treating pain appropriately (Lembke, 2012). Additionally, many states required doctors to take a full day course on pain management (Meldrum, 2003). Pain has also been named as the fifth vital sign and immediately assessed when a patient enters an emergency room. With this type of climate being enforced, many doctors feel that they must treat pain in order to comply with hospital norms and receive higher job performance reviews based on patient satisfaction surveys, in which pain management plays a large role (Lembke, 2012). Until we prioritize addiction as a public health concern in emergency departments, patients with prescription drug abuse problems will continue to receive medications from EDs to feed their addiction.

Recommendations for practice.

Findings from the present study should be considered when making changes to ED policy regarding the management of the drug-seeking patient. The present study found that on average, participants responded “neutral” to being able to identify the drug-seeking patient. Furthermore, when univariate F tests were run on a question directly asking if participants felt confident identifying a patient that was drug-seeking, persons with 5-40 years of experience were significantly more confident in identifying drug-seeking patients than persons with 1-4 years of experience.

Both of these results may indicate that continuing education courses pertaining to drug abuse and the drug-seeking patient would be valuable to the emergency department clinicians. Additionally, clinicians with more experience may be valuable in teaching clinicians beginning their career about looking for signs of drug-seeking behavior. One study regarding drug-seeking patients in the emergency department found it helpful to keep track of all of the patients suspected of drug-seeking to prevent further manipulation of the staff by these patients (Geirderman, 2003). This strategy may be helpful for clinicians that have less experience and may also help them identify patterns of drug-seeking behavior.

Additionally, there was a large spread in the responses regarding frequency of following drug-seeking patient protocol. One aspect of following ED protocol includes checking Ohio’s prescription drug monitoring program, the Ohio Automated Rx Reporting System (OARRS) when prescribing more than three days of narcotic medications. Some resident physician participants reported that they do not have access to the OARRS system and must speak with an attending physician to check the database, making them less likely to do so.

Prescription drug monitoring programs can be excellent resources in objectively looking at a patient's legal controlled substance prescription history. It allows the clinician to see the number of legal controlled substances prescribed and by which providers. One study found that when they compared the clinician's clinical judgment of a drug-seeking patient, versus comparing with the information in the state prescription drug monitoring program, a low (41.2%) positive predictive value was observed (Weiner et al., 2013). This statistic shows prescription drug monitoring programs to more accurately identify drug-seeking patients.

The largest barrier to helping drug-seeking patients with their drug abuse problem was lack of drug abuse counseling staff to counsel these patients. While social workers sometimes get involved with these patients, it is important to have someone that is specialized in addiction handling these patients to take the burden off clinicians. Additionally, many clinicians reported "neutral" in terms of perceived importance of identifying a drug-seeking patient. Having a trained drug abuse counseling member as a part of the emergency department would take the burden of drug abuse counseling off of the ED staff.

Recommendations for improving this research.

One recommendation to improving this research would be to have test retest reliability to ensure the instrument is reliable. Test retest surveys were administered to fourth year medical students interested in emergency medicine, however; only four medical students participated in the study. This did not allow reliability statistics to be run to determine if the instrument was reliable.

Future research

Future research may look to examine other questions, which influence clinician's prescribing behavior. One factor that may be interesting to examine is the relationship between

clinician's treatment of pain (i.e. reserving opioids for severe pain only) and sex, title, and years in current position. This may be helpful in identifying prescribing behaviors that lead to drug overdoses. One study found that prescribing maximum daily doses and longer courses of prescription opioids lead to increase in overdose deaths (Bohnert et al., 2011). Continuing to examine this relationship may lead to fewer morbidities and mortalities caused by prescription drug addiction.

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APPENDIX A

RESEARCH INFORMATION SHEET

IRB #: 2013-2146



Approved:
2/26/2014
Do Not Use After:
12/31/69

**Information Sheet for Research
University of Cincinnati
Department of Health Promotion & Education
Angela Sefcik
Rebecca Vidourek, PhD, CHES (faculty advisor)**

Title of Study: Emergency Department Health Care Provider Perceptions of the Prescription Drug-seeking Patient

Introduction:

You are being asked to take part in a research study. Please read this paper carefully and ask questions about anything that you do not understand.

Who is doing this research study?

The person in charge of this research study is Angela Sefcik, a graduate student of the University of Cincinnati (UC) Master of Public Health Program. Dr. Vidourek is serving as the faculty advisor for this study.

What is the purpose of this research study?

The purpose of this research study is to study health care providers perceptions of drug-seeking patients in the emergency department.

Who will be in this research study?

About 150 health care providers in the Department of Emergency Medicine at University Hospital of Cincinnati. You may be in this study if you are an emergency medicine health care provider.

What will you be asked to do in this research study, and how long will it take?

You are invited to complete an anonymous survey on your perceptions of drug-seeking patients and practices relating to these patients. The questions ask about your thoughts about drug-seeking behavior and your practices in the emergency department relating to these patients. It will take about 10 to 15 minutes to complete. The research will take place by email.

Are there any risks to being in this research study? There are no expected risks to you from completing the survey.

Are there any benefits from being in this research study? The answers you provide may help others or positively influence scientific knowledge. Your participation may help us to develop a continuing education program aimed at emergency medicine health care providers.

Will you have to pay anything to be in this research study? No.

What will you get because of being in this research study? You will not receive any payment for your participation in this research study.

Do you have choices about taking part in this research study?

If you do not want to take part in this research study you do not have to.

How will your research information be kept confidential?

Information about you will be kept private. Your name and other identifying information will not be collected for this study. This way your answers are anonymous.

Agents of the University of Cincinnati may inspect study records for audit or quality assurance purposes.

What are your legal rights in this research study?

Nothing in this consent form waives any legal rights you may have. This consent form also does not release the investigator, the institution, or its agents from liability for negligence.

What if you have questions about this research study?

If you have any questions or concerns about this research study, you should contact Angela Sefcik or Dr. Rebecca Vidourek.

The UC Institutional Review Board (IRB) reviews all research projects that involve human participants to be sure the rights and welfare of participants are protected.

If you have questions about your rights as a participant or complaints about the study, you may contact the Chairperson of the UC IRB at (513) 558-5259. Or, you may call the UC Research Compliance Hotline at (800) 889-1547, or write to the IRB, 300 University Hall, ML 0567, 51 Goodman Drive, Cincinnati, OH 45221-0567, or email the IRB office at irb@ucmail.uc.edu.

Do you HAVE to take part in this research study?

No one has to be in this research study. Refusing to take part will NOT cause any penalty or loss of benefits that you would otherwise have. You may start and then change your mind and stop at any time. If you are under the age of 18, please do not complete the survey.

BY SUBMITTING YOUR COMPLETED SURVEY YOU INDICATE YOUR CONSENT FOR YOUR ANSWERS TO BE USED IN THIS RESEARCH STUDY.

Click on the link below to complete the survey:

PLEASE KEEP THIS INFORMATION SHEET FOR YOUR REFERENCE.

APPENDIX B

SURVEY INSTRUMENT

Please rate how strongly you agree or disagree with each statement.

I feel confident I can recognize if a patient is drug-seeking.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel confident I can effectively prevent patients from obtaining prescription drugs for abuse from the ED.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel confident to deny pain medication to patients I do not feel require it for their medical condition.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel confident I can convince a patient experiencing drug-seeking behaviors to see a counselor.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

If I recognize that a patient is drug-seeking, I feel I could assist them in getting the help they need through a referral from the ED to a behavioral health facility.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel that it is important to talk to all patients in the Emergency Department about the abuse potential of drugs they are being prescribed (i.e. narcotics, benzodiazepines, muscle relaxers, antiemetics, etc.)

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel that inadequately treated pain is a major public health problem.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel that the desire to treat pain contributes to the prescription drug abuse problem.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel that it is important for my Emergency Department to have a policy to decrease drugs prescribed to potential drug-seeking patients.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel that it is important for me to screen patients for substance abuse in the ED.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel that decreasing the number of narcotics prescribed in the ED would reduce overdoses and deaths in the community.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel that screening patients for substance abuse in the ED would reduce drug addiction.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel that my Emergency Department has an effective policy for managing drug-seeking behavior.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel that my Emergency Department has an effective policy for referring drug-seeking patients to mental health professionals.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel The Joint Commission pain care treatment standards make it difficult for me to manage drug-seeking patients appropriately.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel The Joint Commission pain care standards help to increase the rate of prescription drug addiction.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel The Joint Commission pain care treatment standards make it difficult for me to refuse pain medication to patients I do not feel need it.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel that The Joint Commission pain care treatment standards create an environment of more liberal prescribing of opioid pain medications.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel that prescribing narcotics to a drug-seeking patient encourages a chronic drug problem.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel that I would prescribe drugs narcotics to a drug-seeking patient if he or she is disrupting the ED.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel that I would prescribe drugs to a drug-seeking patient if he or she threatens to complain to an administrator.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel that I would prescribe drugs to a drug-seeking patient if he or she threatens to complain to a licensing agency.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel that if I do not prescribe drugs to a drug-seeking patient, I will receive a negative job performance review.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel that if I do not prescribe drugs to a drug-seeking patient, my salary will be reduced.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

I feel that ED policy favor treating pain over reducing the drugs given to drug-seeking patients.

- ☐ Strongly Disagree
- ☐ Disagree
- ☐ Neutral
- ☐ Agree
- ☐ Strongly Agree

How likely is it for you to...?

Suggest a referral for a patient demonstrating drug-seeking behavior to a social worker or mental health facility?

- ☐ Not Likely
- ☐ Slightly Likely
- ☐ Moderately Likely
- ☐ Extremely Likely

Suggest an intervention (i.e. drug rehabilitation, counseling, etc) for a patient demonstrating drug-seeking behavior?

- ☐ Not Likely
- ☐ Slightly Likely
- ☐ Moderately Likely
- ☐ Extremely Likely

Suggest a patient demonstrating drug-seeking behavior talk to a social worker?

- ☐ Not Likely
- ☐ Slightly Likely
- ☐ Moderately Likely
- ☐ Extremely Likely

Confront a patient exhibiting drug-seeking behavior about their potential addiction?

- ☐ Not Likely
- ☐ Slightly Likely
- ☐ Moderately Likely
- ☐ Extremely Likely

Please check all that apply.

Which of the following do you feel is a barrier that prevents health care professionals from helping drug-seeking patients in the ED with their drug abuse problem?

- ☐ Fear of administrative repercussions for not prescribing narcotics
- ☐ Not knowing how to help drug-addicted patients
- ☐ Lack of treatment available for the patient
- ☐ Lack of available drug abuse counseling staff in the ED
- ☐ Lack of professional training to help drug-addicted patients
- ☐ High cost of drug abuse treatment for the patient
- ☐ Patients lacks health insurance to pay for treatment
- ☐ Lack of support from ED administration
- ☐ Lack of support from ED colleagues
- ☐ Patient refusal to get help
- ☐ Other (please explain below)

Please explain

How can we effectively prevent patients from drug-seeking in the Emergency Department?

- ☐ Develop new ED policies to handle drug-seeking patients
- ☐ Offer drug treatment to ED drug-addicted patients
- ☐ Have drug treatment staff available in the ED 24/7
- ☐ Increase availability of community-based treatment
- ☐ Educate public on drug-seeking
- ☐ Improve drug prevention policies
- ☐ Have ED partner with treatment agencies
- ☐ Reduce the number of narcotics prescribed
- ☐ Reduce the number of other prescription drugs prescribed with the potential for abuse
- ☐ Offer drug abuse trainings to current ED staff
- ☐ Offer programs in the ED for drug-seeking patients
- ☐ Ohio Automated Rx Reporting System (OARRS) check for all patients being prescribed narcotics
- ☐ Other (please describe below)

Please explain

How often...

Do you screen your ED patients for drug abuse? (i.e. ask them if they have a problem with drugs, prescription, street, etc.)

- ☐ Never (0%)
- ☐ Rarely (1%-25%)
- ☐ Sometimes (26%-50%)
- ☐ Most of the time (51%-75%)
- ☐ Almost always (76%-99%)
- ☐ Always (100%)

Do you refer drug-seeking patients to substance abuse counseling/treatment?

- ☐ Never (0%)
- ☐ Rarely (1%-25%)
- ☐ Sometimes (26%-50%)
- ☐ Most of the time (51%-75%)
- ☐ Almost always (76%-99%)
- ☐ Always (100%)

Do you follow state recommendations for prescribing pain medication (i.e. 2-3 days of narcotics, etc.)?

- ☐ Never (0%)
- ☐ Rarely (1%-25%)
- ☐ Sometimes (26%-50%)
- ☐ Most of the time (51%-75%)
- ☐ Almost always (76%-99%)
- ☐ Always (100%)

Do you follow ED drug-seeking patient protocol?

- ☐ Never (0%)
- ☐ Rarely (1%-25%)
- ☐ Sometimes (26%-50%)
- ☐ Most of the time (51%-75%)
- ☐ Almost always (76%-99%)
- ☐ Always (100%)

Do you talk to a patient about potential for abuse when you prescribe a narcotic?

- ☐ Never (0%)
- ☐ Rarely (1%-25%)
- ☐ Sometimes (26%-50%)
- ☐ Most of the time (51%-75%)
- ☐ Almost always (76%-99%)
- ☐ Always (100%)

Do you consider abuse potential when you prescribe a narcotic?

- ☐ Never (0%)
- ☐ Rarely (1%-25%)
- ☐ Sometimes (26%-50%)
- ☐ Most of the time (51%-75%)
- ☐ Almost always (76%-99%)
- ☐ Always (100%)

Do you check the Ohio Automated Rx Reporting System (OARRS) when you prescribe a narcotic?

- ☐ Never (0%)
- ☐ Rarely (1%-25%)
- ☐ Sometimes (26%-50%)
- ☐ Most of the time (51%-75%)
- ☐ Almost always (76%-99%)
- ☐ Always (100%)

Do you treat chronic pain in the ED?

- ☐ Never (0%)
- ☐ Rarely (1%-25%)
- ☐ Sometimes (26%-50%)
- ☐ Most of the time (51%-75%)
- ☐ Almost always (76%-99%)
- ☐ Always (100%)

Please check YES or NO for each of the following items:

Do you feel alternative treatments for pain are practical in cases of acute moderate to severe pain? ☐ Yes
☐ No

Do you reserve prescribing narcotics only for patients in cases with acute severe pain? ☐ Yes
☐ No

Do you feel narcotics are necessary to treat mild to moderate pain? ☐ Yes
☐ No

Do you feel your ED over manages pain in the emergency department? ☐ Yes
☐ No

Do you feel your ED under manages pain the emergency department? ☐ Yes
☐ No

Have you ever prescribed narcotics to a patient who is already being treated for chronic pain by another health care provider? ☐ Yes
☐ No

Do patients with certain conditions (i.e. fibromyalgia, sickle cell disease, low back pain, IBD) affect your decision to prescribe prescription medication? ☐ Yes
☐ No

Do you feel prescribing norms at your ED influence the number of opioids you prescribe? ☐ Yes
☐ No

Do you feel prescribing norms at your ED influence you to prescribe a greater number of opioids that you normally would? ☐ Yes
☐ No

Do you feel prescribing norms at your ED influence you to prescribe fewer opioids than you normally would? ☐ Yes
☐ No

Do you feel your ED is concerned with over-administering narcotics? ☐ Yes
☐ No

Do you feel the Ohio Automated Rx Reporting System (OARRS) is an effective way to identify a drug-seeking patient? ☐ Yes
☐ No

Do you feel that developing protocols for all patients exhibiting drug-seeking behaviors in the ED would be practical in reducing the number of medications abused from the ED? ☐ Yes
☐ No

Please check all that apply.

Which of the following sources would you use (now or if they were available) to get information on how to effectively treat drug-seeking patients? (check all that apply)

- ☐ Grand rounds
- ☐ Journals
- ☐ National conferences
- ☐ Internet
- ☐ Continuing education courses on drug abuse
- ☐ Workshops/trainings
- ☐ Distance education courses
- ☐ Other (please describe below)

Please explain

Demographics

Your gender?

- ☐ male
- ☐ female

Your title?

- ☐ Attending physician
- ☐ Resident
- ☐ Medical student
- ☐ Physician's Assistant
- ☐ Nurse Practitioner
- ☐ Nurse

How many years have you been in your current position?

How many years have you worked at your current place of employment?

Your race/ethnicity?

- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Multiracial
- ☐ Other (please explain below)

Please explain

What is your highest degree?

- ☐ Bachelor's
- ☐ Master's
- ☐ M.D./D.O
- ☐ Ph.D.
- ☐ Other (please describe below)

Please explain

Do you have a family member or friend with a drug addiction?

- ☐ Yes
- ☐ No

Please explain

Describe your hospital location

- ☐ Urban
- ☐ Rural
- ☐ Suburban

Please use the following space to list or discuss any additional thoughts you have on the drug-seeking problem as it relates to your profession.
