Regulatory Management of Substance Use in High-Risk Nurse Populations

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The regulatory management of nurses with substance use disorders has continued to evolve based on emerging evidence. In 2008, the National Council of State Boards of Nursing convened an interdisciplinary committee to review current literature and evidence and provide evidence-based recommendations on the regulatory management of nurses with substance use disorders. The committee also identified several populations at high risk for substance abuse or relapse. These populations include nurses being treated with prescription drugs, such as analgesics, anxiolytics, antidepressants, and potentially mind-altering drugs for such conditions as chronic pain, depression, anxiety, chemical dependence, and addiction. This article addresses the regulatory management of practicing nurses with this dual challenge of having a substance use disorder and a medical need to use drugs that can trigger relapse.

Learning Objectives

- Discuss the challenges of a nurse with a substance abuse disorder who requires prescribed medication.
- Identify assessment techniques for nurses with a substance abuse disorder who require prescribed medications.
- Describe monitoring techniques for nurses with a substance abuse disorder who require prescribed medications.
- Compare commonly abused prescription drugs.

In 2008, a nine-member interdisciplinary committee convened by the National Council of State Boards of Nursing (NCSBN) reviewed current literature and evidence and provided evidence-supported recommendations on the regulatory management of nurses with substance use disorders. The result of the committee's work is *Substance use disorder in nursing: A resource manual and guidelines for alternative and disciplinary monitoring programs* published in 2011.

During this work the committee identified several nurse populations who have a high risk of substance abuse relapse and who therefore need stringent assessment, treatment, and monitoring. These populations include nurses being treated with prescription drugs, such as analgesics, anxiolytics, antidepressants, and other potentially mind-altering drugs for such conditions as chronic pain, depression, anxiety, and addiction. This article addresses the regulatory management of practicing nurses in this population; that is, nurses with the dual challenge of having a substance use disorder and a medical need for prescription medications that may lead to relapse.

Regulating Safe Practice

Regulating the practice of nurses involves only one issue: Can the nurse practice safely? Boards of nursing (BONs) often deal with nurses who cannot practice safely because of the treatment they are receiving. Other nurses are unable to practice safely because of the dual challenge of such treatment and chemical dependence. Preventing drug abuse is an important societal goal, but law enforcement agencies, health care practitioners, and patient advocates agree that it should not affect patients' ability to receive the care they need and deserve (Drug Enforcement Administration et al., 2001).

Whether a nurse should continue practicing nursing depends on the nurse's ability to function safely and effectively. Assessing functional ability is an individualized process that must consider all relevant factors, such as diagnosis, prescribed treatment, situational events, and the effects of these factors on the nurse's ability to practice safely (Idaho Board of Nursing, 2005).

Dual Challenge: Chronic Pain and Substance Use Disorder

Promoting pain relief and guarding against abuse of pain medications is a difficult balancing act. Chemically dependent nurses who are in recovery and take prescribed drugs with addictive potential for pain h ave a substantial risk of relapse and compromise of their recovery. Nurses often identify pain issues as the

start of a cascading problem. Addicted nurses tell BONs that pain led to overuse or abuse of prescription drugs. (See Table 1.) Prescription misuse evolved into drug-seeking behaviors that ultimately resulted in using multiple providers, fraudulent prescriptions, and drug diversion. Poorly managed pain can lead to self-medication, drug-seeking behavior, and pseudoaddiction.

More than half of the adults in the United States have chronic or recurrent pain (Peter D. Hart Research Associates, 2003). The estimated prevalence of substance misuse in the general population with chronic pain ranges from 0% to 50%, depending on the definition used and the samples examined (Hojsted & Sjogren, 2007). How many nurses suffer from chronic pain and substance use disorders is unknown. Trinkoff and Storr (1998) suggested that the number of nurses with substance abuse is on par with that of the general population.

Addiction and pain specialists note that the assessment of pain in substance-dependent populations is complicated by the lack of objective measures to assess pain. These specialists often have mixed feelings on how to best treat this population, and the pain management community widely endorses the idea that pain exists whenever the patient says it does (Modesto-Lowe, Johnson, & Petry, 2007). Opiates are widely accepted as an appropriate and effective method of relieving chronic pain, regardless of the patient's substance abuse history. A practicing nurse who uses opiates or who has a dual diagnosis that includes substance use disorder presents challenges for patient safety and nursing regulation.

Common symptoms of relapse in this population include aberrant medication-taking behaviors (conduct that involves taking medications in a manner that is not prescribed), obtaining prescription drugs from multiple providers and pharmacies, purchasing prescription-only medications from a nonmedical source or international sources, forging prescriptions, and obtaining and using illicit drugs (Ballantyne & Mao, 2003). Nurses with easy access to controlled substances in the workplace have the potential to misappropriate or divert the substances, and appropriate patient safeguards must be put into place.

Dual Challenge: Mental Illness and Substance Use Disorder

Mental health issues can affect a nurse's judgment and subsequent care of patients. Both mental illness and substance abuse disorders are noted for their hallmark of denial; often the affected nurse is the last to recognize that the behavioral manifestations of such diseases are putting the nurse's practice in danger.

The National Alliance on Mental Illness suggests that those who struggle with serious mental illness and substance abuse face problems of enormous proportions because both conditions affect the individual's ability to function, handle daily activities, and relate to others (National Alliance on Mental Illness, n.d.).

Buckley (2006) posits that substance use disorders can occur at any phase of mental illness. Causes of this comorbidity include self-medication, genetic vulnerability, environment, lifestyle, underlying shared origins, and a common neural substrate. The consequences of the dual diagnosis, says Buckley, include poor medication compliance, physical comorbidities, poor health, poor self-care, increased suicide risk or aggression, increased sexual behavior, and incarceration. Screening and assessing the patient and providing an integrated treatment plan that addresses substance abuse and mental illness are important tools in managing the dual diagnosis.

Dual Challenge: Medication-Assisted Treatment

Opioids and marijuana can become substances of abuse when prescribed to nurses in treatment for chemical dependence.

Opioid Addiction

The Center for Substance Abuse Treatment consensus panel recommends that medication-assisted treatment (MAT) for opioid addiction as provided in opioid treatment programs be conceptualized in terms of phases of treatment, so interventions are matched to levels of patient progress and intended outcomes (Batki, Kauffman, Marion, Parrino, & Woody, 2005). When patients are discharged from treatment and aftercare and they enter a stable recovery, questions arise about whether medications such as buprenorphine and methadone are appropriate.

According to some researchers, chronic drug users can display neuropsychological impairment in the domains of executive and memory function (Loeber, Kniest, Diehl, Mann, & Croissant, 2008). Individual factors influence the degree to which neuropathology or changes in the brain exist. Research on the cognitive effects of MAT on the recovering health professional does not exist. Studies are needed to investigate the effects of methadone and buprenorphine maintenance treatment, especially regarding dose-dependent effects, because high to very high doses of both seem to have the potential to ameliorate cognitive functioning (Loeber et al., 2008).

Nurses in MAT face distinct employment challenges, especially as employers increasingly impose preemployment drug testing. One challenge these nurses face is deciding whether to disclose their recovery status. Nurses must be advised to answer all job application questions honestly and must be counseled on ways to manage disclosure of their treatment status.

A nurse who is in documented recovery may be covered under the Americans with Disabilities Act (ADA) of 1988, federal legislation that protects from discrimination nurses with substance use disorders who are in recovery. While the illegal use of drugs or alcohol is not included within the ADA's definition

TABLE 1

Commonly Abused Prescription Drugs

Substances: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered	*Intoxication Effects*/Health Risks
Depressants			*Sedation/drowsiness, reduced anxiety, feelings of well-being, lowered inhibitions, slurred speech, poor concentration, confusion, dizziness, impaired coordination and memory/*slowed pulse, lowered blood pressure, tolerance, withdrawal, addiction; increased risk of respiratory distress and death when combined with alcohol *for barbiturates*—euphoria, fever, irritability/life-threatening withdrawal in chronic users
Barbiturates	*Amytal, Nembutal, Seconal, Phenobarbital:* barbs, reds, red birds, phennies, tooies, yellows, yellow jackets	II, III, IV/injected, swallowed	
Benzodiazepines	*Ativan, Halcion, Librium, Valium, Xanax, Klonopin:* candy, downers, sleeping pills, tranks	IV/swallowed	
Sleep Medications	*Ambien (zolpidem), Sonata (zaleplon), Lunesta (eszopiclone)*	IV/swallowed	
Opioids and Morphine Derivatives			*Pain relief, euphoria, drowsiness, sedation, weakness, dizziness, nausea, impaired coordination, confusion, dry mouth, itching, sweating, clammy skin, constipation/* slowed or arrested breathing, lowered pulse and blood pressure, tolerance, addiction, unconsciousness, coma, death; risk of death increased when combined with alcohol or other CNS depressants *for codeine*—less analgesia, sedation, and respiratory depression than morphine *for methadone*—used to treat opioid addiction and pain; significant overdose risk when used improperly *for fentanyl*—80–100 times more potent analgesic than morphine *for oxycodone*—muscle relaxation/ twice as potent analgesic as morphine; high abuse potential
Codeine	*Empirin with Codeine, Fiorinal with Codeine, Robitussin A-C, Tylenol with Codeine:* Captain Cody, Cody, schoolboy; (with glutethimide: doors & fours, loads, pancakes and syrup)	II, III, IV/injected, swallowed	
Morphine	*Roxanol, Duramorph:* M, Miss Emma, monkey, white stuff	II, III/injected, swallowed, smoked	
Methadone	*Methadose, Dolophine:* fizzies, amidone, (with MDMA: chocolate chip cookies)	II/swallowed, injected	
Fentanyl and Analogs	*Actiq, Duragesic, Sublimaze:* Apache, China girl, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash	II/injected, smoked, snorted	
Other Opioid Pain Relievers: Oxycodone HCL Hydrocodone Bitartrate Hydromorphone Oxymorphone Meperidine Propoxyphene	*Tylox, Oxycontin, Percodan, Percocet:* Oxy, O.C., oxycotton, oxycet, hillbilly heroin, percs *Vicodin, Lortab, Lorcet:* vike, Watson-387 *Dilaudid:* juice, smack, D, footballs, dillies *Opana, Numorphan, Numorphone:* biscuits, blue heaven, blues, Mrs. O, octagons, stop signs, O Bomb *Demerol, meperidine hydrochloride:* demmies, pain killer *Darvon, Darvocet*	II, III, IV/chewed, swallowed, snorted, injected, suppositories	
Stimulants			*Feelings of exhilaration, increased energy, mental alertness/*increased heart rate, blood pressure, and metabolism, reduced appetite, weight loss, nervousness, insomnia, *seizures, heart attack, stroke* *for amphetamines—rapid breathing, tremor, loss of coordination, irritability, anxiousness,* panic, paranoia, hallucinations, impulsive behavior, aggressiveness, tolerance, addiction *for methylphenidate*—increase or decrease in blood pressure, loss of appetite, weight loss
Amphetamines	*Biphetamine, Dexedrine, Adderall:* bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II/injected, swallowed, smoked, snorted	
Methylphenidate	*Concerta, Ritalin:* JIF, MPH, R-ball, Skippy, the smart drug, vitamin R	II/injected, swallowed, snorted	

* Schedule I and II drugs have a high potential for abuse. Schedule I drugs are available for research only and have no approved medical use. Schedule II drugs are available only by prescription and require a new prescription for each refill. Schedule III and IV drugs are available by prescription, may have five refills in 6 months, and may be ordered orally.

Source: National Institute on Drug Abuse (NIDA). Visit NIDA at www.drugabuse.gov

per se, a person is covered when he or she is participating in a supervised rehabilitation program and is no longer engaging in the misuse of drugs or alcohol or is erroneously regarded as engaging in the use of drugs. The ADA ensures that a person in active recovery will not face discrimination in the job arena.

Marijuana for Medical Purposes

The legalization of marijuana for medical purposes is an emerging issue, and some states have already passed legislation for prescribed medical use. This presents another challenge for regulatory management.

Alternative programs focus on the rehabilitation process and support for recovering nurses to remain active in nursing. These programs often allow the recovering nurse to return to work (Fogger & McGuinness, 2009). Because of the psychotropic effects of marijuana (and of higher doses of pain medications), the nurse's ability to practice safely is uncertain. Until further evidence exists, it is recommended that nurses using marijuana for medical purposes be prohibited from participating in an alternative program and be monitored in the disciplinary program of the BON (National Council of State Boards of Nursing [NCSBN], 2011).

Assessment and Monitoring

The management and treatment of nurses dually diagnosed with addiction and a condition requiring prescribed medications that can be abused are controversial and complex, and they require expertise and increased vigilance. In a study by Dunbar and Katz (1996), 45% of patients who had a history of chronic nonmalignant pain and substance abuse demonstrated aberrant medication-taking behavior consistent with relapse while taking opiates to manage pain. As with other studies, those who relapsed during treatment for chronic pain were not active in a 12-step program and had less than 3 years of sobriety.

Other risk factors included a lack of family support, a recent history of polysubstance abuse, and failure of treatment to relieve chronic pain. When considering accepting a nurse with a recent active addiction and a prescription for a controlled substance or a medication that could cause impairment, BONs and alternative programs must exercise caution and increased surveillance. (See Table 2.)

The goals of monitoring nurses with substance use disorders and pain or other conditions are to decrease the potential for relapse and ensure the nurse is safe to practice while taking these medications. To achieve these goals, programs use such measures as neuropsychological evaluation to assess cognition, problem solving, memory, and judgment as well as drug testing or screening and electronic prescription monitoring.

TABLE 2

Alternative Programs Versus Disciplinary Programs for Chemically Dependent Nurses in Pain

The two common approaches to regulatory management of chemically dependent nurses in pain and taking pain medication are the alternative program and the disciplinary program. Many boards of nursing (BONs) offer alternative programs for nurses who meet certain criteria. Whether a nurse can be referred to an alternative program or continue in such a program depends on the program's criteria for participation, the nurse's situation, and the scope of the program. For some nurses, a formal contract with the BON's disciplinary arm rather than the alternative program would be required.

According to the *2007 NCSBN Member Board Profiles,* 43 BONs have alternative programs for chemically dependent nurses who meet entry criteria. Of the 43 programs, 13 accept nurses with dual diagnoses with physical or health problems.

The advantages of an alternative program include early identification, intervention, and treatment for chemical dependence and pain. Nurses able to continue or return to nursing practice are monitored to ensure compliance with program requirements. Nurses who meet program expectations and complete the terms of their agreement or contract avoid a disciplinary history. Nurses who do not comply with their program agreements are referred to the BON for disciplinary action.

BONs that do not offer alternative programs to nurses with dual diagnoses use the disciplinary process to manage a nurse's chemical dependence and pain issues. Although in some states the disciplinary process may take longer than the alternative program, the BON has the full force and effect of administrative law supporting its orders.

Source: Disciplinary Resources Committee—Attachment A: *Regulatory Implications of Pain Management Resource Pack Business Book.* NCSBN 2008 Annual Meeting.

Professional Evaluation

A nurse may need a professional evaluation to determine whether he or she should continue practicing nursing when the practice may be compromised. If the nurse lacks the insight to realize when serious safety issues exist, the BON is the ultimate decision maker. BONs often seek professional assistance in determining a nurse's ability to practice safely. When a BON weighs the nurse's desire to practice nursing, the public's need for access to care, and the BON's responsibility to protect the public, the professional findings may be crucial to the determination.

Some BONs are authorized by law, upon demonstration of probable cause, to require physical or mental health evaluations as part of the investigatory process (NCSBN, 2004). A BON not authorized to require such an evaluation might request that the nurse comply with a recommendation for an evaluation. Another approach is for the BON to make tentative findings

on the condition that the nurse has a thorough evaluation by a BON-approved evaluator.

BON staff and attorneys may be involved in the selection of professional evaluators. An experienced, qualified health care professional should be selected to assess the nurse's cognitive and physical abilities. A professional evaluation regarding the impact of pain on a nurse's ability to practice is complex. Ideally, a collaborative approach provides input from different professional perspectives. All evaluators should have experience evaluating persons whose medical knowledge and experience could skew the evaluation findings.

Assessments should be conducted at the time of day that most closely mirrors the nurse's work schedule. Also, the nurse must be on his or her normal medication regimen for the evaluation. The BON should not be concerned about the type or amount of medication; rather, the BON should focus on whether the nurse is able to think clearly and function safely.

Drug Screening and Behavioral Monitoring

For those prescribed medications that can cause impairment, the risk of relapse is greater, and the ability to detect early relapse through drug screening may be compromised.

Urine testing is a practical and important tool used to monitor compliance with substance abstinence requirements. However, urine testing has limitations when the nurse is taking a prescribed controlled substance for a medical disorder. Therefore, in nurses who have a substance use disorder and a chronic pain disorder treated with controlled substances, drug screen test results should not be the only means used to detect relapse or monitor treatment and alternative program compliance.

Behavioral monitoring combined with drug screening creates a more comprehensive monitoring system than either one on its own (Dunbar & Katz, 1996). Behavioral monitoring must include workplace restrictions and supervision along with routine audits of the nurse's workplace for access to controlled substances.

Electronic Prescription Monitoring

Thirty-eight states have adopted laws establishing electronic prescription monitoring programs (EPMPs), and other states are in the process of proposing, preparing, or considering legislation (Center for Practical Bioethics, 2009). Under most programs, the providers or pharmacies send records of prescribed controlled substances to a state-based, centralized regulatory agency, which monitors whether individuals are receiving prescriptions from multiple providers.

The EPMP also allows the provider to verify whether a patient is receiving prescriptions from other providers. Information from the EPMP can help monitor nurses and provide information for providers and disciplinary and alternative programs.

Requirements for Alternative Programs

Nurses who have a substance use disorder and need a prescribed mood-altering or potentially impairing medication may be able to participate in an alternative program if they agree to the following:

- At least 5 years of monitored practice and recovery
- A neuropsychological evaluation before returning to nursing practice and at any time cognition appears to be negatively impacted because of illness or treatment
- Treatment with a provider who has expertise in addictions and pain management and submits monthly provider progress reports
- Use of one pharmacy for all medications and provision of quarterly prescription profiles
- Regular verification of prescriptions obtained through the EPMP, if available
- Direct supervision when practicing nursing
- No night shift, no shift longer than 10 hours, and no more than 40 work hours per week (or fewer than 40 hours per week, depending upon provider recommendation)
- Monthly reports from the employer for the first year and if no identified issues, quarterly thereafter
- No access to controlled substances in the workplace for at least 12 months if a history of diversion, prescription fraud, or multiple prescribers exists
- Written notification to nursing employer and monitoring program of any changes to medications, including addition, deletion, or change in dosage, before assuming patient-care duties
- Submission of a letter from provider confirming safe-to-practice with any changes in medication
- Agreement to immediately cease practice upon notification of noncompliance or symptoms suggestive of or known to be part of a relapse
- Random drug screening, weekly during the first year and three times a month during the second year, tapering to a minimum of two times a month if fully compliant
- Attendance at 12-step meetings at least three times a week to provide accountability and connection to other substance-free individuals
- Attendance at a weekly nursing support meeting
- Participation in relapse prevention therapy with a provider who has expertise in pain management, addiction, and relapse

The purpose of the above guidelines is to provide a structure of accountability for the nurse. According to NCSBN (2011), "alternative programs rest on the rationale that they can quickly remove someone from practice and provide a path to recovery for nurses with a substance use disorder" (p. 203).

Summary

Nurses with the dual challenge of a substance use disorder and the need for a prescribed medication that puts their sobriety at risk present complex issues for BONs. Such nurses must be screened carefully before entering alternative or discipline monitoring programs, and mechanisms must be in place to support treatment and rehabilitation while ensuring patient safety. The opinion of a professional evaluator regarding both pain and chemical dependence issues can aid the BON's decision on a nurse's suitability for these programs, and the BON can ensure additional monitoring and surveillance.

However, the nurse must have insight into how the combination of chemical dependence, pain, and pain treatment affect his or her ability to practice safely. When this insight is lacking, the final authority as well as the power to remove the nurse from practice quickly rests with the BON.

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Regulatory Management of Substance Use in High-Risk Nurse Populations

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Regulatory Management of Substance Use in High-Risk Nurse Populations

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Contact hours: 1.4
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Posttest

Please circle the correct answer.

1. The percentage of adults in the United States who have chronic or recurrent pain is more than
a. 10%.
b. 30%
c. 40%.
d. 50%.

2. Which of the following statements about patients with a substance abuse disorder who also need medications for chronic pain is correct?
a. There is universal agreement on how to manage this patient population.
b. Opiates are not accepted as an appropriate method of relieving chronic pain.
c. Symptoms of relapse in this population include aberrant medication taking.
d. Assessment is completed through objective measures of pain level.

3. Which of the following statements about nurses with a substance abuse disorder who take prescribed drugs for pain with addictive potential is correct?
a. They have no greater risk of relapse.
b. They are less likely to relapse.
c. They are at substantial risk for relapse.
d. They are 50% less likely to relapse.

4. Which statement about mental illness and a substance abuse disorder is correct?
a. Nurses with substance abuse disorders are more likely than those with mental illness to admit a problem.
b. Nurses with both conditions usually admit that they have a problem.
c. Nurses with both conditions frequently deny they have a problem.
d. Nurses with depression are more likely than those with a substance abuse disorder to admit a problem.

5. Which of the following is an example of effects from a dual diagnosis of mental illness and substance abuse disorder?
a. Increased suicide risk
b. Decreased self-medication
c. Better medication adherence
d. Improved physical health

6. Which statement about a nurse in recovery is correct?
a. Studies have established that methadone treatment is harmful to cognitive functioning.
b. Studies have established that buprenorphine treatment is harmful to cognitive functioning.
c. A nurse who is in documented recovery is excluded from coverage by the Americans with Disabilities Act of 1988.
d. A nurse who is in documented recovery may be covered under the Americans with Disabilities Act of 1988 and therefore protected from discrimination.

7. Which statement about nurses with a substance abuse disorder who are receiving medical marijuana is correct?
a. They should participate in the alternative program of the board of nursing (BON).
b. They should be monitored in the disciplinary program of the BON.
c. They are able to practice nursing safely.
d. They are able to practice in critical care.

8. Which statement about evaluation of a nurse with a substance abuse disorder who requires medication for medical conditions is correct?
a. If a board of nursing isn't authorized to require an evaluation, it cannot request one.
b. A professional evaluation is not necessary since the nurse can self-identify whether he or she can continue to practice.
c. The evaluator should have experience evaluating persons whose medical knowledge and experience could skew the evaluation findings.
d. The professional evaluator should be a licensed attorney.

9. A professional evaluation of a nurse should:
a. be conducted at the time of day that mirrors the nurse's work schedule.
b. be conducted outside the nurse's normal work time.
c. include discontinuing the nurse's prescribed medication 12 hours before the evaluation.
d. include discontinuing the nurse's prescribed medication 24 hours before the evaluation.

10. Which is an example of behavioral monitoring?
a. Urine testing
b. Workplace restrictions
c. Laboratory testing
d. Allowing independent practice

11. Nurses with a substance abuse disorder who take a prescribed medication for another condition may be eligible to participate in an alternative program if they agree to:
a. work night shift only twice a month.
b. work night shift only once a month.
c. at least 10 years of monitored practice and recovery.
d. at least 5 years of monitored practice and recovery.

12. Which requirement should nurses with a substance abuse disorder and the need for prescribed medications for other conditions meet to participate in an alternative program?
a. Working no shift longer than 12 hours
b. Working no more than 50 hours each week
c. Attending 12-step meetings at least three times a week
d. Attending 12-step meetings once a week

13. Which statement about alternative and disciplinary programs for chemically dependent nurses in pain is correct?
a. In most states, alternative programs result in later treatment for dependence.
b. Alternative programs do not have strict guidelines for participation.
c. Disciplinary programs allow for early identification of chemical dependence.
d. Alternative programs allow for early intervention of chemical dependence.

14. Which of the following commonly abused prescription drugs is Schedule IV?
a. Methadone
b. Meperidine
c. Methylphenidate
d. Dexomethorphan

15. Which of the following commonly abused prescription drugs is snorted?
a. Ativan
b. Codeine
c. Methylphenidate
d. Dexomethorphan

16. Which of the following commonly abused prescription drugs is known by the street name "white stuff"?
a. Fentanyl
b. Ambien
c. Morphine
d. Codeine

Evaluation Form (required)

1. Rate your achievement of each objective from 5 (high/excellent) to 1 (low/poor).

- Discuss the challenges of a nurse with a substance abuse disorder who requires prescribed medication.

1 2 3 4 5

- Identify assessment techniques for nurses with a substance abuse disorder who require prescribed medications.

1 2 3 4 5

- Describe monitoring techniques for nurses with a substance abuse disorder who require prescribed medications.

1 2 3 4 5

- Compare commonly abused prescription drugs.

1 2 3 4 5

Rate each of the following items from 5 (very effective) to 1 (ineffective):

2. Were the authors knowledgeable about the subject?

1 2 3 4 5

3. Were the methods of presentation (text, tables, figures, etc.) effective?

1 2 3 4 5

4. Was the content relevant to the objectives?

1 2 3 4 5

5. Was the article useful to you in your work?

1 2 3 4 5

6. Was there enough time allotted for this activity?

1 2 3 4 5

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