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COURSE #31133 — 2 CONTACT HOURS **RELEASE DATE: 02/01/24** **EXPIRATION DATE: 01/31/27**

Texas Nursing Jurisprudence and Ethics

This course fulfills the Texas requirement for 2 hours of education on Jurisprudence and Ethics required every third renewal period.

If you have already completed your Texas Nursing Jurisprudence and Ethics requirement, you may skip this course and still receive 20 hours of CE.

CONTINUING EDUCATION
FOR TEXAS NURSES
2024

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Audience

This course is designed for all nurses licensed in Texas.

Course Objective

The purpose of this course is to provide basic knowledge of the laws and rules governing the practice of nursing in Texas in order to increase compliance and improve patient care. Texas nurses are legally obligated to be aware of standards that govern professional accountability. Information contained in this course is not intended to be used in lieu of lawful guidelines, but as a learning tool that increases the understanding of some regulations as they apply to nurses who are licensed within the state of Texas.

Learning Objectives

Upon completion of this course, you should be able to:

1. Outline the pertinent levels of nursing practice in Texas and the general scope of practice of each.
2. Identify specific laws and rules related to the practice of nursing in Texas.
3. Differentiate between ethical and legal practice.
4. Discuss the legal and ethical requirements related to professional boundaries and unprofessional conduct in nursing.

Faculty

Mary Franks, MSN, APRN, FNP-C, is a board-certified Family Nurse Practitioner and NetCE Nurse Planner. She works as a Nurse Division Planner for NetCE and a per diem nurse practitioner in urgent care in Central Illinois. Mary graduated with her Associate's degree in nursing from Carl Sandburg College, her BSN from OSF Saint Francis Medical Center College of Nursing in 2013, and her MSN with a focus on nursing education from Chamberlain University in 2017. She received a second master's degree in nursing as a Family Nurse Practitioner from Chamberlain University in 2019. She is an adjunct faculty member for a local university in Central Illinois in the MSN FNP program. Her previous nursing experience includes emergency/trauma nursing, critical care nursing, surgery, pediatrics, and urgent care. As a nurse practitioner, she has practiced as a primary care provider for long-term care facilities and school-based health services. She enjoys caring for minor illnesses and injuries, prevention of disease processes, health, and wellness. In her spare time,

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she stays busy with her two children and husband, coaching baseball, staying active with her own personal fitness journey, and cooking. She is a member of the American Association of Nurse Practitioners and the Illinois Society of Advanced Practice Nursing, for which she is a member of the bylaws committee.

Faculty Disclosure

Contributing faculty, Mary Franks, MSN, APRN, FNP-C, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Special Approvals

This activity is designed to comply with the requirements of California Assembly Bill 241, Implicit Bias.

This course fulfills the Texas requirement for 2 hours of education on Jurisprudence and Ethics.

About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

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This course represents an educational model that promotes the importance of learning objectives and individualized learning. Study questions will appear throughout the course to create a link between the learning objectives and the supporting text.

INTRODUCTION

What is the purpose of the Texas Board of Nursing Position Statements?

Nursing practice acts have a long history in the United States, with the first standards being enacted in the early 1900s [1]. In 1907, nineteen nurses from around the state formed the Texas Graduate Nurses' Association in Fort Worth. These women had a collective interest in establishing standards for the delivery of nursing care and creating a nursing board [1]. Using recent Colorado legislation as a model, the Graduate Nurses' Association advocated for nursing legislation in Texas. The Nurses Registration Act of 1909 (an early version of the Nursing Practice Act) passed the Texas Legislature, and thus the Board of Nurse Examiners, which became the Board of Nursing in 2007, was created [1].

The Texas Nursing Practice Act has undergone extensive revision and amendment since 1909 [1; 2]. Legislated to safeguard the public, its purpose is to ensure that minimum safety requirements are met by every nurse practicing in the state. The Nursing Practice Act (i.e., Chapter 301 of the Texas Occupations Code) includes laws and rules regulating nursing education, licensure, and practice [2]. Chapter 301 establishes the Texas Board of Nursing as an authority to adopt rules, develop standards for nursing programs, and discipline nurses who violate regulations [2]. Nurses who fall below the Board's required minimum competency; who present a danger to patients, coworkers, or others; or who fail to comply with all Board of Nursing rules will be prohibited from working in the state.

In addition to Chapter 301 (the Nursing Practice Act), the Board of Nursing stipulates that Texas nurses are required to be familiar with Chapter 303 (Nursing Peer Review) and Chapter 304 (the Nurse Licensure Compact) [2]. Several chapters of the Texas Administrative Code, which is a collection of all state agency rules, also pertain to nursing education, licensure, practice, and discipline. Together, these laws and rules form the basis for the legal practice of nursing and the regulation of nursing by the State of Texas. Although they are not technically laws, the Texas Board of Nursing Position Statements provide guidance regarding patient safety, scope of practice, and other important issues; the Board strongly encourages that nurses read all Position Statements, or at the very least, the Summary of Position Statements [3]. Texas nurses should also be familiar with the principles of nursing ethics and have a firm understanding of professional boundaries [3].

This course fulfills the continuing education requirement on jurisprudence and ethics related to the practice of nursing in Texas for all levels of nursing, including registered nurses (RNs), licensed vocational nurses (LVNs), registered nurse first assistants (RNFAs), and advanced practice registered nurses (APRNs) [3]. While this course will provide an overview of several pertinent sections of the laws and rules, all nurses are required to have up-to-date knowledge of them in their entirety in order to ensure compliance, retain licensure, and practice safely.

STANDARDS OF NURSING PRACTICE

The basic standards of competent practice directly impact how all nurses in Texas provide care. Not only must a nurse possess the knowledge of lawful and current care standards, but the knowledge must be demonstrated through consistent practice and intervention to prevent unauthorized, inappropriate, erroneous, illegal, contraindicated, or intentional nonperformance of care.

The Nursing Practice Act governs the practice of LVNs, RNs, APRNs, and RNFAs. LVNs are those persons licensed to practice vocational nursing, while RNs, APRNs, and RNFAs are all licensed to practice professional nursing, with various levels of specialization [3]. Both professional and vocational nurses are responsible and accountable for making decisions that are based upon their educational preparation and experience in nursing.

LICENSED VOCATIONAL NURSING

According to the Texas Nursing Practice Act, the practice of vocational nursing is defined as a "directed scope of nursing practice, including the performance of an act that requires specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biologic, physical, and social science as acquired by a completed course in an approved school of vocational nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures." Vocational nursing involves [2]:

- Collecting data and performing focused nursing assessments of the health status of an individual
- Participating in the planning of the nursing care needs of an individual
- Participating in the development and modification of the nursing care plan
- Participating in health teaching and counseling to promote, attain, and maintain the optimum health level of an individual
- Assisting in the evaluation of an individual's response to a nursing intervention and the identification of an individual's needs
- Engaging in other acts that require education and training, as prescribed by Board rules and policies, commensurate with the nurse's experience, continuing education, and demonstrated competency

Additionally, the Board of Nursing and the Nursing Practice Act state that an LVN requires appropriate supervision of an RN, APRN, physician assistant, physician, dentist, or podiatrist [2]. The LVN is required to function within the parameters of the legal scope of practice and in accordance with the federal, state, and local laws, rules, regulations, and policies, procedures, and guidelines of the employing healthcare institution or practice setting. LVNs are "responsible for providing safe, compassionate, and focused nursing care to assigned patients with predictable healthcare needs" [4].

PROFESSIONAL NURSING

The practice of professional nursing is defined as "the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biologic, physical, and social science as acquired by a completed course in an approved school of professional nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures." Professional nursing involves [2]:

- Observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes
- Administration of a medication or treatment as ordered by a physician, podiatrist, or dentist
- Maintenance of health or prevention of illness
- Performance of an act delegated by a physician
- The development of the nursing care plan
- Supervision or teaching of nursing
- Administration, supervision, and evaluation of nursing practices, policies, and procedures
- Requesting, receiving, signing for, and distribution of prescription drug samples to patients at practices at which an APRN is authorized to sign prescription drug orders

The Board of Nursing further defines the scope of practice of professional nursing [5]:

> The RN takes responsibility and accepts accountability for practicing within the legal scope of practice and is prepared to work in all healthcare settings, and may engage in independent nursing practice without supervision by another healthcare provider. The RN, with a focus on patient safety, is required to function within the parameters of the legal scope of practice and in accordance with the federal, state, and local laws; rules and regulations; and policies, procedures and guidelines of the employing healthcare institution or practice setting. The RN is responsible for providing safe, compassionate, and comprehensive nursing care to patients and their families with complex healthcare needs.

Advanced Practice Registered Nursing

APRNs are registered nurses who have completed additional accredited advanced-practice education and internship as recognized by the Board of Nursing [6]. The Board of Nursing specifies that APRNs must practice within their individual scope in the advanced role, meaning the particular specialty and population focus that the nurse trained for in an advanced program [7]. The scope of practice may be defined by APRN organizations; however, in many instances, it can be up to the APRN's employer or supervisor to determine what duties he or she can perform and what types of patients can be treated [7]. This decision may be based on the nurse's clinical experience and his/her knowledge, skills, and competencies. APRNs may or may not practice the full scope of the professional role and specialty for which they trained, and an APRN is allowed to perform the full scope of duties of an RN. The Board suggests asking the following questions in order to help decide if an activity is within an individual APRN's scope of practice [7]:

- Is it consistent with the scope of one's recognized title or does it evolve into another advanced practice title recognized by the Board requiring additional formal education and legal recognition?
- Is it consistent with the Standards of Nursing Practice outlined in Board Rule 217.11?
- Are you willing to accept accountability and liability for the activity and outcomes?
- Is it consistent with one's education in the role and specialty?
- Is it consistent with one's professional scope of practice?
- Is it consistent with reasonable and prudent practice?
- Is it consistent with statutory or regulatory laws?
- Is it consistent with evidence-based care?

APRNs may assign tasks to RNs and LVNs, but the task must be within the RN's/LVN's scope of practice [8]. The Texas Board of Nursing states (in Position Statement 15.18) that RNs are expected to carry out orders issued by APRNs if the orders are within the APRN's scope of practice for their specialty [9]. RNs are expected to question an order if it is believed to be non-efficacious or contraindicated.

TEXAS NURSING PRACTICE RULES

In what instances should a nurse be reported to the Board?

In addition to the Nursing Practice Act, there are several chapters of the Texas Administrative Code (i.e., Chapters 211–228) that contain rules pertinent to nursing. Texas Administrative Code Rule 217.11 (Standards of Nursing Practice) contains the minimum acceptable standards for all licensed nurses. It states that the Board of Nursing is responsible for regulating the practice of nursing within the State of Texas for LVNs, RNs, and APRNs, and that action against the nurse's license may result from a failure to meet the minimum acceptable level of practice, even if no patient injury results from a nurse's actions or inactions [10]. All nurses practicing in Texas must meet the minimum acceptable standards specified in Rule 217.11, which includes requirements to [10]:

- Know and conform to the Texas Nursing Practice Act and the Board's rules and regulations as well as all federal, state, or local laws, rules, or regulations affecting the nurse's current area of nursing practice
- Implement measures to promote a safe environment for clients and others
- Know the rationale for and the effects of medications and treatments and correctly administer the same
- Accurately and completely report and document: the client's status, including signs and symptoms; nursing care rendered; physician, dentist, or podiatrist orders; administration of medications and treatments; client response(s); and contacts with other healthcare team members concerning significant events regarding client's status
- Respect the client's right to privacy by protecting confidential information unless required or allowed by law to disclose the information
- Promote and participate in education and counseling to a client(s) and, where applicable, the family/significant other(s) based on health needs
- Obtain instruction and supervision as necessary when implementing nursing procedures or practices
- Make a reasonable effort to obtain orientation/training for competency when encountering new equipment and technology or unfamiliar care situations
- Notify the appropriate supervisor when leaving a nursing assignment
- Know, recognize, and maintain professional boundaries of the nurse-client relationship
- Comply with mandatory reporting requirements of Texas Occupations Code Chapter 301 (Nursing Practice Act), Subchapter I, which include reporting a nurse: who violates the Nursing Practice Act or a Board rule (except for minor incidents as stated in the Nursing Practice Act and Board rules) and contributed to the death or serious injury of a patient; whose conduct causes a person to suspect that the nurse's practice is impaired by chemical dependency or drug or alcohol abuse; whose actions constitute abuse, exploitation, fraud, or a violation of professional boundaries; or whose actions indicate that the nurse lacks knowledge, skill, judgment, or conscientiousness to such an extent that the nurse's continued practice of nursing could reasonably be expected to pose a risk of harm to a patient or another person, regardless of whether the conduct consists of a single incident or a pattern of behavior
- Provide, without discrimination, nursing services regardless of the age, disability, economic status, gender, national origin, race, religion, health problems, or sexual orientation of the client served
- Institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications
- Clarify any order or treatment regimen that the nurse has reason to believe is inaccurate, non-efficacious, or contraindicated by consulting with the appropriate licensed practitioner and notifying the ordering practitioner when the decision is made not to administer the medication or treatment
- Implement measures to prevent exposure to infectious pathogens and communicable conditions
- Collaborate with the client, members of the healthcare team and, when appropriate, the client's significant other(s) in the interest of the client's health care
- Consult with, utilize, and make referrals to appropriate community agencies and health care resources to provide continuity of care
- Be responsible for one's own continuing competence in nursing practice and individual professional growth
- Make assignments to others that take into consideration client safety and that are commensurate with the educational preparation, experience, knowledge, and physical and emotional ability of the person to whom the assignments are made
- Accept only those nursing assignments that take into consideration client safety and that are commensurate with the nurse's educational preparation, experience, knowledge, and physical and emotional ability
- Supervise nursing care provided by others for whom the nurse is professionally responsible
- Ensure the verification of current Texas licensure or other compact state licensure privilege and credentials of personnel for whom the nurse is administratively responsible, when acting in the role of nurse administrator.

As noted, nurses are required to be familiar with all Standards of Nursing Practice. Please refer to Chapter 217 of the Texas Administrative Code for Rule 217.11 in its entirety.

ETHICAL AND LEGAL ISSUES IN NURSING PRACTICE

What ethical concepts are central to nursing practice?

In addition to their legal obligations, nurses have ethical obligations to their patients. The practice of nursing is primarily one of caring, and the ethical theories for nursing are often referred to as "the ethics of caring." Nurses are expected to address both ethical and legal issues in their practice, which can be complex. As medical advancements and new technology progress, these must be incorporated into established ethical standards. The American Nurses Association has established the Code of Ethics for Nurses, which is intended to act as "the ethical standard for the profession and provides a guide for nurses to use in ethical analysis and decision-making" [11]. The full text of this Code is available at https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses.

Major ethical issues that may arise in the practice of nursing are related to the provision of patient-centered care, advocacy, delegation, self-care, and supporting colleagues and the profession [11]. Ethical concepts central to patient-centered care include advocacy, confidentiality, privacy, self-determination, and the dignity and worth of all persons. Ethical concepts central to nursing practice include accountability (i.e., accepting responsibility for one's action or inaction), beneficence (i.e., the duty to do good), competence (i.e., only performing duties within one's scope of practice, acquiring new skills and education), nonmaleficence (i.e., the duty to do no harm), veracity (i.e., truthfulness), and social reform (e.g., advocating for patients and groups). Additionally, as a nurse gains experience in his or her field and specialty, the ethic of teaching comes into play. This can simply involve helping an inexperienced nurse grow by passing along knowledge, or can involve more specific leadership, supervisory, or teaching roles.

Several ethical issues are addressed in the Texas Board of Nursing Position Statements [9]. These include the issue of initiation of cardiopulmonary resuscitation (CPR) in long-term care residents in the absence of a do not resuscitate (DNR) order (e.g., when initiation of CPR would appear futile and inappropriate given the nursing assessment of the resident, despite the premise that a DNR order may only be given by a physician). Other ethical issues discussed in the Position Statements include care of those with whom the nurse has a personal relationship and issues of patient confidentiality and privacy with regard to the use of social media. Reading, thought, and discussion about ethics and potential ethical dilemmas can help nurses respond appropriately and can help prevent unethical behaviors from occurring in the workplace.

There are also a variety of legal issues that affect the provision of nursing care and maintenance of a nursing license. It is important to note that, although possibly related, the laws governing nursing practice are different from the ethical framework(s) that nurses use to guide decision making. Laws pertaining to documentation, licensure, and standards of care have been established to ensure that nurses practice within a defined scope of practice and are aware of the boundaries of independent nursing action and responsibilities. These laws also act to hold nurses accountable for maintaining an acceptable standard of patient care. However, perhaps the greatest legal concern for nurses is the threat of negligence or malpractice claims.

The tort (or medical malpractice) liability system is intended to provide deterrence to clinicians who willful or negligently injure patients; deterrence is theoretically achieved by holding practitioners legally liable for their actions or omissions [12]. According to tort law, four elements must be established for a ruling of malpractice [13]:

- Duty: The nurse owed a duty to meet a particular standard of care.
- Breach of duty: The nurse failed to perform the owed duty.
- Causation: There is a causal connection between the nurse's failure and the patient's injury.
- Damages: An injury occurred for which monetary compensation is adequate relief.

These elements must be shown by a "preponderance of the evidence," defined as more than 50% probability, a lower standard than the "beyond a reasonable doubt" used in criminal law [14; 15]. Malpractice cases are decided on the basis of what a "jury is likely to think is fact" rather than actual fact [16].

PROFESSIONAL BOUNDARIES AND UNPROFESSIONAL CONDUCT

What nursing actions constitute unprofessional conduct?

Another facet of ethical care and practice involves maintaining appropriate limits in the nurse/patient relationship. Based on the idea that there is an imbalance of power and potential for abuse in this relationship (due to the nurse's power and the patient's vulnerability), the State of Texas requires all nurses to be familiar with and abide by the laws and rules regarding the limits of the nurse/patient relationship [3; 17]. Nurses should strive to promote the patient's best interests, dignity, and independence and refrain from inappropriate involvement in the patient's personal relationships and/or the obtainment of personal gain at the patient's expense. Violating professional boundaries of the nurse/patient relationship includes, but is not limited to, emotional, financial, physical, or sexual exploitation of the patient or the patient's family [16]. These violations and other types of unprofessional conduct are grounds for disciplinary action by the Board.

The State of Texas defines unprofessional conduct, in Texas Administrative Code Rule 217.12, as "unprofessional or dishonorable behaviors of a nurse that the Board believes are likely to deceive, defraud, or injure clients or the public" [17]. These behaviors include but are not limited to [17]:

- Unsafe practice, including, but not limited to:
  - Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Rule 217.11
  - Carelessly or repeatedly failing to conform to generally accepted nursing standards in applicable practice settings
  - Improper management of client records
  - Delegating or assigning nursing functions or a prescribed health function when the delegation or assignment could reasonably be expected to result in unsafe or ineffective client care
  - Accepting the assignment of nursing functions or a prescribed health function when the acceptance of the assignment could be reasonably expected to result in unsafe or ineffective client care
  - Failing to supervise the performance of tasks by any individual working pursuant to the nurse's delegation or assignment
  - Failure of a clinical nursing instructor to adequately supervise or to assure adequate supervision of student experiences
- Failure of a chief administrative nurse to follow appropriate and recognized standards and guidelines in providing oversight of the nursing organization and nursing services for which the nurse is administratively responsible
- Failure to practice within a modified scope of practice or with the required accommodations, as specified by the Board in granting a coded license or any stipulated agreement with the Board
- Careless or repetitive conduct that may endanger a client's life, health, or safety (whether or not actual injury to a client is established)
- Inability to practice safely, as defined by demonstration of actual or potential inability to practice nursing with reasonable skill and safety to clients by reason of illness; use of alcohol, drugs, chemicals, or any other mood-altering substances; or as a result of any mental or physical condition
- Misconduct, including, but not limited to:
  - Falsifying reports, client documentation, agency records, or other documents
  - Failing to cooperate with a lawful investigation conducted by the Board
  - Causing or permitting physical, emotional, or verbal abuse or injury or neglect to the client or the public, or failing to report same to the employer, appropriate legal authority, and/or licensing board
  - Violating professional boundaries of the nurse/client relationship, including but not limited to physical, sexual, emotional, or financial exploitation of the client or the client's significant other(s)
  - Engaging in sexual conduct with a client, touching a client in a sexual manner, requesting or offering sexual favors, or language or behavior suggestive of the same
  - Threatening or violent behavior in the workplace
  - Misappropriating, in connection with the practice of nursing, anything of value or benefit, including, but not limited to, any property (real or personal) of the client, employer, or any other person or entity; or failing to take precautions to prevent such misappropriation
  - Providing information that was false, deceptive, or misleading in connection with the practice of nursing
  - Failing to answer specific questions or providing false or misleading answers that would have affected the decision to license, employ, certify, or otherwise utilize a nurse
  - Offering, giving, soliciting, or receiving or agreeing to receive (directly or indirectly) any fee or other consideration to or from a third party for the referral of a client in connection with the performance of professional services
- Failure to pay child support payments as required by the Texas Family Code§232.001
- Diversion or attempts to divert drugs or controlled substances
- Dismissal from a Board-approved peer assistance program for noncompliance and referral by that program to the Board
- Other drug-related actions or conduct including, but not limited to:
  - Use of any controlled substance or any drug (prescribed or unprescribed), device, or alcoholic beverages while on duty or on call and to the extent that such use may impair the nurse's ability to safely conduct to the public the practice authorized by the nurse's license

  - Falsification of or making incorrect, inconsistent, or unintelligible entries in any agency, client, or other record pertaining to drugs or controlled substances
  - Failing to follow the policy and procedure in place for the wastage of medications at the facility where the nurse was employed or working at the time of the incident(s)
  - A positive drug screen for which there is no lawful prescription
  - Obtaining or attempting to obtain or deliver medication(s) through means of misrepresentation, fraud, forgery, deception, and/or subterfuge
- Unlawful practice, including, but not limited to:
  - Knowingly aiding, assisting, advising, or allowing an unlicensed person to engage in the unlawful practice of vocational, registered, or advanced practice nursing
  - Violating an order of the Board; carelessly or repetitively violating a state or federal law relating to the practice of vocational, registered, or advanced practice nursing; or violating a state or federal narcotics or controlled substance law
  - Knowingly aiding, assisting, advising, or allowing a nurse under Board order to violate the conditions set forth in the order
  - Failing to report violations of the Nursing Practice Act and/or the Board's rules and regulations
- Leaving a nursing assignment (including a supervisory assignment) without notifying the appropriate personnel

WORKPLACE VIOLENCE

In 2018, the Board issued a new position statement addressing workplace violence [9]. It is important for the interprofessional team to work collaboratively in support of an effective violence prevention program. This includes acknowledging the value of a safe, violence-free workplace; ensuring and exhibiting equal commitment to the safety and health of workers and patients; and maintaining a system of accountability for all involved members of the healthcare team [9].

THE USE OF SOCIAL MEDIA

The issue of exploitive or inappropriate use of patient information or images on social media is becoming increasingly significant. As discussed, the Board of Nursing Position Statement 15.29: Professional Boundaries Including Use of Social Media by Nurses offers clarification on the relevant ethical and legal issues regarding this topic, including the use of social media as a beneficial tool for nurses and patients alike. The statement emphasizes that confidentiality and privacy extend to online posts or conversations and, more specifically, that [9]:

- Patient-related images are not to be transmitted via electronic media, regardless of whether the patient is identified by name; taking photo or video of patients with personal devices, including cell phones, is prohibited. Images taken for legitimate purposes, using employer-provided devices, may be allowed based on employer policy.
- Use caution when having online social contact with patients or former patients. The fact that a patient may initiate contact with the nurse does not permit a personal relationship.
- Nurses should not make disparaging remarks about patients, co-workers, or employers on social media, even if persons are not identified.

For the full text of the Position Statement regarding the use of social media by nurses, and all other Position Statements, please visit https://www.bon.texas.gov/practice_bon_position_statements.asp.html.

CONCLUSION

It is the responsibility of the Texas Board of Nursing to enforce the rules regulating the practice of nursing as the rules are currently stated—not how individuals may wish them to be. As nurses are affected by these rules and regulations, they have the responsibility to keep informed of regulatory changes in order to maintain licensure. It should be remembered that practicing within the minimum standards, though a necessity, is not all that is expected of nurses. Fulfilling ethical obligations to patients, co-workers, employers, and society is also an important part of health care, and it is only when the regulatory and ethical aspects of practice are combined that a nurse can be fully effective.

Customer Information/Evaluation insert located between pages 16–17.

COURSE #90120 — 2 CONTACT HOURS　　RELEASE DATE: 09/01/23　　EXPIRATION DATE: 08/31/26

Pulmonary Embolism

Includes 1 Pharmacotherapeutic/Pharmacology Hour

Audience

This course is designed for nurses, physicians, and PAs involved in assessing, triaging, and managing patients with suspected pulmonary embolism.

Course Objective

The purpose of this course is to provide healthcare professionals with the knowledge and clinical strategies necessary to optimally triage and treatment patients with pulmonary embolism.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define a thromboembolic event.
2. Explain pathogenesis, risk factors, and demographics of pulmonary embolism (PE).
3. Review the diagnostic workup of PE.
4. Compare the different types of PE treatments in both inpatient and outpatient settings.

Faculty

Dalia Saha, MD, is a board-certified internal medicine physician with more than 15 years of clinical experience. With experience in both academic and private healthcare settings, Dr. Saha has vast exposure to many aspects of patient care and clinical medicine. Always interested in the didactic component of health care, Dr. Saha works on the education committee for the American College of Physicians and is an instructor and teaching staff for medical students and residents in George Washington University and Johns Hopkins Medical Schools. Lauded by her colleagues for her dedication and work ethic in the field of medicine, she has been awarded the Top Doctor Award in Washington, DC.

Faculty Disclosure

Contributing faculty, Dalia Saha, MD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planner and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the study questions and course material for better application to your daily practice.

INTRODUCTION

How are pulmonary emboli categorized?

Pulmonary embolism (PE) is very common in both inpatient and outpatient settings [1; 2]. It should be one of the first considerations when a patient presents with acute-onset dyspnea, shortness of breath, and chest pain. Other common symptoms include cough, hemoptysis, diaphoresis, and feverishness.

A PE is an abrupt occlusion of the pulmonary artery and/or one of its branches. The occlusion may consist of blood clot/thrombus, air, fat, or malignancy/tumor originating in another part of the body, which dislodges and travels through the venous system to the right side of the heart and thence the pulmonary vasculature. In most cases, PE arises from deep vein thrombophlebitis in the lower legs or pelvis, following trauma, surgery, infection, or an acquired hypercoagulable state.

The natural history of PE is variable. PE may be single or multiple (pulmonary emboli), small and clinically silent, large or recurrent with progressive obliteration of the pulmonary vascular bed, causing cardiorespiratory failure. Symptomatic PE is commonly associated with significant morbidity and mortality risk; the challenge for clinical care providers is early recognition and prompt therapeutic intervention to relieve pulmonary artery obstruction and prevent additional pulmonary emboli, any one of which could prove fatal [1; 2]. With modern technology, which can detect small embolic events, the condition is identified much earlier, making possible effective treatment prior to complete hemodynamic collapse [1; 2; 3]. Assessment and prevention in outpatient settings have also led to improvements in mortality. Research indicates that small, subclinical pulmonary emboli probably occur with some frequency but are transient in nature and go unnoticed; however,when there is predisposition to venous stasis (e.g., inflammation, injury, heart failure, coagulopathy), single large or recurrent PE becomes a challenging clinical illness requiring prompt diagnosis and treatment.

Classification of PE typically categorizes the disease as hemodynamically stable or unstable. The most common type is hemodynamically stable, which can range from small, mildly symptomatic or asymptomatic PE (previously referred to as low-risk PE or small PE) to those who present with right ventricular dysfunction but who are hemodynamically stable (previously referred to as submassive or intermediate-risk PE) [3; 4]. While PE characterized by right ventricular dysfunction can be hemodynamically stable, more severe (unstable) disease is characterized by the presence of systemic arterial hypotension, which indicates at least half of the pulmonary vascular tree is affected [4; 5]. Hemodynamically unstable PE (previously referred to as massive or high-risk PE) will result in significant hypotension. Hemodynamic instability is defined as the presence of cardiac arrest requiring resuscitation, or obstructive shock or persistent hypotension not caused by other pathologies [36].

EPIDEMIOLOGY

The annual incidence of PE is difficult to pinpoint but is estimated to be about 60 to 70 cases per 100,000 population [6]. General autopsy studies from all-cause mortality have found PE, variable in number and age, to be present in 30% to 45% of cases [6; 7; 8; 9].

Behind only stroke and coronary artery disease, PE is one of the most common types of cardiovascular disease. It is more common in patients 60 to 70 years of age, with the highest incidence in patients 70 to 80 years of age. Although death following a diagnosis of PE is relatively common, as high as 30%, many of these patients have coexisting serious conditions, such as cancer, recent surgery, or sepsis. The direct mortality associated with undiagnosed/untreated PE during the course of diagnosis and treatment is about 5% to 8%. An estimated

10% of patients with acute PE die suddenly; approximately two-thirds of patients who die from PE do so within two hours of presentation. The mortality rate for those treated for hemodynamically unstable PE is about 20%, and those with cardiogenic shock have a mortality rate of 25% to 30%. Those with a hemodynamically stable PE have a mortality rate of 1% to 25%, depending on the degree of right ventricular dysfunction [2; 4; 5; 10].

PATHOPHYSIOLOGY

What is the most common underlying cause of PE?

Most commonly, a PE occurs when a deep vein thrombus detaches and migrates, or embolizes, into the pulmonary circulation. This can lead to blockage of the pulmonary vasculature, causing a ventilation-perfusion (VQ) mismatch and impairing gas exchange and circulation. PE is more common in the lower lung fields, compared with the upper ones, and both lungs are typically involved. Peripheral PE, as opposed to central PE, can lead to a pulmonary infarction coupled with alveolar hemorrhage. As further obstruction of the pulmonary artery occurs, there is an increase in dead space ventilation and elevation of pulmonary arterial pressure by increasing pulmonary vascular resistance. This further worsens VQ mismatch, with vascular occlusion of the arteries.

Various serum factors are released during a PE formation, including serotonin and thromboxane, which are produced from activated platelets [1; 2; 4]. This induces a cascade of hormonal triggers and related vasoconstriction. Pulmonary arterial pressure increases, which worsens right ventricular afterload and can lead to right ventricular failure and eventually left ventricular system failure. Further clinical progression will lead to a myocardial ischemia due to inadequate coronary circulatory flow, systemic hypotension, and eventual death [1; 4; 5].

DIAGNOSIS

What conditions are included in the differential diagnosis of PE?

A strict (confirmatory) diagnosis of PE would require direct anatomic evidence of pulmonary artery obstruction, which by modern imaging technique (e.g., computed tomography [CT] angiography) would involve invasive measures and exposure to radiation. As the size and distribution (severity) of PE are variable, the preferred strategy for selecting diagnostic testing relies on degree of clinical suspicion, clinical judgment, and assessment of pre-test probability. Selection of noninvasive testing to rule out the diagnosis, based on the assessed clinical probability of PE, has proved effective in reducing the use of CT imaging, thereby minimizing lung and breast-tissue exposure to irradiation [27]. The differential diagnosis includes heart failure, pneumothorax, pneumonia, sepsis, acute chest syndrome, chronic obstructive pulmonary disease (COPD) exacerbation, and anxiety or other psychotropic illnesses. A systematic review and meta-analysis found that a history of sudden dyspnea, syncope, thrombophlebitis, previous deep vein thrombosis, leg swelling, active cancer, or recent surgery was associated with an increased probability of PE [54]. An inability to increase alveolar oxygen pressure (PaO_2) greater than 8.0 kPa (60 mm Hg) despite high-flow oxygen should also raise suspicion for PE.

When a patient does not speak the same language as the clinician, a professional interpreter should be consulted to ensure accurate communication. A retrospective chart review found that, for non-English-speaking patients suspected of having sustained a PE, the positive diagnostic yield of pulmonary angiogram for those who requested an interpreter (7.37%) was nearly double that of those who did not request an interpreter (3.23%) [49].

DIAGNOSTIC WORKUP

Vital Signs

In initial evaluation, vital signs such as blood pressure, heart rate, and rapid estimation of oxygenation by pulse oximetry are critical to assessing severity of vascular compromise and the stability of the patient. Arterial blood gas (ABG) testing will confirm if a patient has hypoxemia and can be used to obtain the arterial-alveolar gradient to determine if there is a PE or other VQ mismatch [10; 11; 12; 13].

D-dimer Level

Assessment of D-dimer levels can be used for screening purposes and to rule out PE if the pretest probability is intermediate or low. D-dimer is a byproduct of intrinsic fibrinolysis. It is considered to be a highly sensitive test for the absence of PE and has a very high negative predictive value. A normal D-dimer level effectively rules out PE or deep vein thromboembolism. In the event that the d-dimer is elevated, further testing (e.g., computed tomography [CT] angiography, planar VQ scanning) can be performed [10; 14; 15; 16]. Because the test is not specific, an elevated finding is not diagnostic. The specificity of D-dimer decreases with age, and the use of age-adjusted cut-offs is recommended for patients older than 50 years of age. The formula is age (years) x 10 mcg/L for patients older than 50 years of age.

Cardiac Biomarkers

Cardiac biomarker testing may also be useful, particularly as it can identify other diagnoses (e.g., myocardial infarction) [10; 11; 17]. It may help identify signs of right ventricular strain and/or ischemia. An elevated brain natriuretic peptide (BNP) level may indicate right ventricular dysfunction, and higher levels correlate with greater severity of dysfunction.

Various cardiac troponins have also been assessed for diagnostic significance in patients with PE. While these measurements are not diagnostic, elevated troponin is significantly associated with higher mortality in patients with PE [18].

MODIFIED PROSPECTIVE INVESTIGATION OF PULMONARY EMBOLISM DIAGNOSIS (PIOPED-II) CRITERIA

Probability of PE	Criteria
High probability	Two or more large mismatched segmental perfusion defects or the arithmetic equivalent of moderate and/or large defects
Normal perfusion or very low probability	No perfusion defects Nonsegmental perfusion defects without other perfusion defects in either lung Perfusion defects smaller than corresponding chest x-ray opacity One to three small subsegmental perfusion defects Two or more matched ventilation and perfusion defects with a regionally normal chest x-ray and some areas of normal perfusion elsewhere Solitary triple-matched defect in a single segment in the middle or upper lung zone Stripe sign Large pleural effusion without other perfusion defects in either lung
Low or intermediate probability	All other findings

Source: [19] *Table 1*

Imaging

Diagnostic imaging is indicated for patients in whom PE cannot be ruled out based on clinical assessment and noninvasive testing. For these patients, CT pulmonary angiography is usually an easily accessible diagnostic imaging modality. It is fast, accurate, and both specific and sensitive. It is also useful for identifying other lung pathology, such as pneumonia and effusions [15; 16]. However, it does require that the patient have good renal function due to the use of iodinated contrast, and it also entails lung and breast-tissue irradiation. Ventilation-perfusion single-photon-emission CT (VQ scan) is a low-radiation option to minimize radiation exposure in younger patients.

Chest x-ray is nonspecific but can help identify pleural effusions and diaphragmatic changes. The classic Westermark sign, which shows a clarified area (loss of vascular markings) distal to a large occluded vessel, and Hampton hump, a dome-shaped, pleural-based opacification, may be present on x-ray. These findings are strongly specific for PE (92% and 82%, respectively) but are not sensitive (14% and 22%, respectively). Chest x-ray can also assist in ruling out pneumonia as part of the differential.

VQ scans visualize areas that are ventilated but not perfused (i.e., VQ mismatch). This testing requires more time, is less specific than CT angiography, and should be done with clinical correlation. However, it is the imaging modality of choice for patients with suspected PE and normal chest x-ray for whom CT angiography is contraindicated, including those with impaired kidney function and pregnant patients. Normal ventilation is 4 L air/minute, and normal perfusion is 5 L blood/minute; thus, a normal VQ ratio is 0.8. A high VQ ratio (>0.8) indicates that the patient's ventilation is exceeding perfusion, while a low VQ ratio indicates a VQ mismatch caused by poor ventilation. When blood is diverted away from the occluded section, overperfusion can occur in the normally ventilated regions. The modified Prospective Investigation of Pulmonary Embolism Diagnosis (PIOPED-II) criteria score the probability of PE based on VQ scan findings (***Table 1***).

Duplex ultrasonography for detection of lower extremity venous thrombi is a useful noninvasive test to assess risk and probability in a patient suspected of having PE. It has both high sensitivity and specificity for thrombus [14; 20; 21; 22]. However, a negative test result does not rule out PE, as the thrombus may have dislodged and embolized prior to the testing.

Electrocardiogram

Electrocardiographic signs of right ventricle strain, such as T wave inversions in V1–V4, QR pattern in V1, the S1Q3T3 pattern, and incomplete or complete right bundle-branch block, are useful but insensitive for the assessment of right ventricle dysfunction in acute PE. However, the presence of right ventricular strain on electrocardiogram has been shown to correlate with the extent of pulmonary vascular obstruction and outcomes of acute PE [10; 11; 12; 14; 17; 24].

Echocardiogram

Echocardiography can demonstrate if there was a clot in the right atrium or ventricle and can also be used to show if there are signs of right ventricular dilatation and hypokinesis [12]. When performed, echocardiography has been shown to reduce other testing and lead to more aggressive early therapy [12; 22].

Pulmonary Arteriography

Pulmonary arteriography is a rare test typically performed only on patients with suspected PE for whom CT and chest x-ray are not feasible. It may also be used with cardiac catheterization to assess patients who have chronic thromboembolic pulmonary hypertension to determine if they are good candidates for pulmonary endarterectomy.

GENETIC TESTING

Factor V Leiden (FVL) and prothrombin (PT) genetic variants are associated with an increased risk of future venous thrombosis or PE. Genetic tests for FVL and PT variants are widely available and commonly used. One current use of these tests is to inform decisions regarding anticoagulant medication in order to decrease the risk of future clots (i.e., secondary prevention). The independent Evaluation of Genomic Applications in Practice and Prevention (EGAPP) Working Group found enough evidence to recommend against routine testing for FVL and PT gene variants in adults who have idiopathic venous thromboembolism, since longer term preventive treatment with anticoagulant medication offers similar benefits to patients whether or not they have these genetic variations. They also recommend against routine testing for adult family members who do not have a history or symptoms of venous thromboembolism, when the testing is conducted to help decide whether to treat them preventively with anticoagulant medication [50]. However, for patients with venous thromboembolism associated with commonly recognized modifiable risk factors (e.g., contraceptive use, estrogen replacement), genetic testing may help guide preventive treatment decisions.

CLINICAL SCORING SYSTEMS

The Wells criteria (***Table 2***) and the PE Rule-Out Criteria (PERC) assist clinicians with determining clinical probability for PE [14]. One of the important criteria in the determination of PE is if there is a more likely alternate diagnosis, and this is somewhat subjective. If the Wells criteria are used, a score greater than 6 is considered high probability of PE, 2–6 is moderate probability, and less than 2 is low probability. A modification of the Wells criteria simplifies scoring to either likely (>4) or unlikely (≤4).

The PERC rule was developed for use in emergency care to rule-out PE in patients whose likelihood of PE is low (<15%), so unnecessary diagnostic workups can be avoided. The PERC rule includes [26]:

- Age younger than 50 years
- Heart rate less than 100 beats per minute
- Oxygen saturation of at least 95%
- No prior deep vein thrombosis or PE
- No unilateral leg swelling
- No hormonal estrogen use
- No hemoptysis
- No history of surgery or trauma requiring prior hospitalization in the previous four weeks

If all eight criteria are fulfilled, the patient's risk for PE can be considered sufficiently low and further testing is not necessary [10; 11; 13; 17]. In practice, clinicians tend to overestimate the probability of PE. In cases in which the clinician judges that the patient is very unlikely to have PE but is uncertain whether the estimated likelihood is <15%, the PERC rule or Wells score ≤4 in combination with a normal D-dimer level is reassuring and can be used to safely rule out PE.

WELLS CRITERIA

Clinical Features	Points
Clinical symptoms of deep vein thromboembolism	3
Other diagnosis less likely than PE	3
Tachycardia (>100 beats per minute)	1.5
Immobilization for three or more days OR surgery in the past four weeks	1.5
Previous deep vein thromboembolism or PE	1.5
Hemoptysis	1
Malignancy	1

Source: [25] *Table 2*

TREATMENT

INITIAL MANAGEMENT

The mainstays of initial PE management focus on rapid assessment of clinical severity and stabilization of the patient. As noted, when a patient initially presents, the most critical pieces of information lie in their vital signs (e.g., heart rate, blood pressure, oxygenation). The initial goal for the patient with PE is to maintain oxygen levels. If mechanical circulatory support is required, cardiopulmonary bypass permits right ventricular recovery by decompressing the dilated and dysfunctional ventricle through diversion of the cardiac output to a pump and oxygenator [51]. Alternatively, venoarterial extracorporeal membrane oxygenation (VA-ECMO) functions similarly but is more mobile, allowing for support to be initiated and continued in more diverse settings.

For patients who are hemodynamically unstable, intravenous fluid should be given with caution, because this can lead to right ventricular overload. Hemodynamically stable, low-risk patients should receive anticoagulation alone; those who are at high risk and have hemodynamic compromise may require systemic thrombolysis or surgical- versus catheter-directed therapy. Those who are at intermediate risk have more complicated cases and can be treated with either anticoagulation alone or anticoagulation with potential procedures. As discussed, the risk level will depend on the severity of right ventricular dysfunction on echocardiography, the degree of troponin elevation, the amount of oxygen and vasopressor required, and clot burden and location [10; 11; 12; 13]. The American Society of Hematology (ASH) recommends that patients with PE at low risk for complications be offered home treatment rather than hospital treatment [27].

The therapeutic treatment strategy for patients with a new diagnosis of PE, and venous thromboembolism in general, can be divided into three phases: initial treatment (the first three weeks after diagnosis), primary treatment (three to six months, or longer), and secondary prevention (beginning upon completion of primary therapy and continuing indefinitely) [27]. For primary treatment of patients with PE, whether unprovoked or provoked by a transient or chronic risk factor, the ASH suggests a shorter course of anticoagulation therapy (3 to 6 months) be preferred over a longer course (6 to 12 months). Anticoagulation therapy may be continued indefinitely in select patients for whom the risk for bleeding complications is less than the risk of recurrent PE.

PRIMARY PHARMACOTHERAPY

In selecting initial pharmacotherapy, European guidelines and a 2022 clinical practice review recommend that treatment be guided by risk stratification of PE as high, intermediate, or low based on the patient's clinical presentation [36; 55]. Approximately 5% of patients present with signs of high-risk PE (e.g., shock, end-organ hypoperfusion/dysfunction, blood pressure <90 mm Hg) not caused by arrhythmia, hypovolemia, or intrinsic heart failure [55]. Intermediate-risk patients are those who present with echocardiographic evidence of right heart strain, elevated cardiac biomarkers, or both; those who are hemodynamically stable with normal cardiac biomarkers and no evidence of right ventricular strain are classified as having low-risk PE. Patients classified as having high-risk PE are candidates for initial reperfusion (thrombolytic) therapy; those with intermediate- and low-risk PE should receive immediate anticoagulation therapy [36; 55]. Treatment should be started promptly whenever PE is strongly suspected and the patient's risk of serious bleeding complications is low. Pharmacotherapy options for initial anticoagulation include intravenous unfractionated heparin, subcutaneous low-molecular-weight heparin, subcutaneous fondaparinux, factor Xa inhibitors (e.g., apixaban, rivaroxaban), direct thrombin inhibitors (e.g., dabigatran), and intravenous argatroban for patients with heparin-induced thrombocytopenia.

Thrombolytic Therapy

Patients who present with high-risk PE warrant consideration for immediate reperfusion therapy, there being no contraindications (e.g., brain metastases, bleeding disorders, recent surgery) [36; 55]. Intravenous systemic thrombolysis is a readily available option for reperfusion. Thrombolytic agents act to dissolve the thrombus by converting plasminogen into plasmin. With early thrombus resolution, the elevated pulmonary arterial pressure/resistance and accompanying right ventricular dysfunction improve rapidly. Thrombus resolution within the first 24 hours in particular is much faster in thrombolytic therapy than with heparin [52].

The first recombinant tissue plasminogen activator, and the most commonly used thrombolytic agent used in patients with PE, is alteplase (rtPA); other available agents include streptokinase, urokinase, reteplase, and tenecteplase. The main indication for thrombolysis is high-risk PE with thrombus and hemodynamic instability. rtPA is administered at a rate of 50 mg per hour for two hours; the dose should be reduced for patients with weight less than 65 kg. If streptokinase, is used, a loading dose of 250,000 IU is given, followed by and infusion of 100,000 IU per hour for 24 hours. Urokinase is started with a loading dose of 4,400 IU and an infusion of 4,400 IU/kg/hour for 12 hours [29; 52].

According to the American College of Physicians, catheter-directed thrombolytic therapy can be considered if cardiopulmonary deterioration is imminent [53]. There is some evidence that ultrasound-assisted catheter-directed thrombolysis is superior to heparin anticoagulation alone in improving right ventricular dilatation within 24 hours without major bleeding complications or recurrent embolism. Absolute contraindications to thrombolytic therapy include history of intracranial hemorrhage, known structural cerebral vascular lesion, known malignant intracranial neoplasm, recent history (within past three months) ischemic stroke, active bleeding (excluding menses), and recent history (within past three months) significant closed-head trauma or facial trauma [52; 53].

Oral Anticoagulants

Direct oral anticoagulants (DOACs) (factor Xa inhibitors or direct thrombin inhibitors) are recommended over vitamin K antagonists (e.g., warfarin) for most patients; however, those with renal insufficiency (i.e., creatinine clearance <30 mL/min), moderate-to-severe liver disease, or antiphospholipid syndrome are not good candidates for DOAC therapy [27].

EB
EVIDENCE-BASED PRACTICE RECOMMENDATION

The European Society of Cardiology (ESC) and European Respiratory Society (ERS) recommends direct oral anticoagulants (DOACs) as first choice anticoagulants over warfarin even in those who are warfarin eligible.

(https://academic.oup.com/eurheartj/article/41/4/543/5556136. Last accessed August 18, 2023.)

Level of Evidence: Expert Opinion/Consensus Statement

Factor Xa inhibitors such as apixaban and rivaroxaban have the advantage of fixed dosing and no need for monitoring laboratory values, both of which are required of vitamin K antagonists. Rivaroxaban and apixaban do not require any kind of overlap with an intravenous agent. Dose reductions are indicated for those with renal insufficiency. Apixaban can be used in patients with renal insufficiency and is safe for patients on dialysis [2; 28]. Reversal agents are available: idarucizumab for reversal of dabigatran, and andexanet alfa for apixaban and rivaroxaban.

The half-life of factor Xa inhibitors is much shorter than the half-life of warfarin. If bleeding develops and requires

ORAL ANTICOAGULATION THERAPY	
Agent	**Dosage**
Vitamin K Antagonist	
Warfarin	5 mg once daily for most patients[a]
Direct Thrombin Inhibitor	
Dabigatran etexilate	After at least 5 days of initial therapy with a parenteral anticoagulant, transition to oral 150 mg twice daily.
Factor Xa Inhibitors	
Apixaban	10 mg twice daily for 7 days, followed by 5 mg twice daily
Edoxaban	After at least 5 days of initial therapy with a parenteral anticoagulant, transition to once-daily oral 60 mg for patients >60 kg or 30 mg for patients ≤60 kg.
Rivaroxaban	15 mg twice daily with food for 21 days, followed by 20 mg once daily with food

[a] For patients who are expected to be more sensitive to warfarin, a starting dose of 2.5 mg daily is recommended. After three days of treatment, dosage should be adjusted based on INR values.

Source: [29] *Table 3*

reversal, a four-factor prothrombin complex concentrate can be used. Direct thrombin inhibitors such as dabigatran can also be used for treatment for these patients. For those with heparin-induced thrombocytopenia, intravenous argatroban or subcutaneous fondaparinux can be used for anticoagulation. The dosage varies according to agent (***Table 3***).

Drug-drug interactions with DOACs are common and may increase risk of bleeding or thrombosis. Important DOAC interactions are often due to medications that affect cytochrome P450 (CYP450) enzymes or transport proteins or increase bleeding propensity.

Warfarin, which used to be the mainstay of therapy, is no longer considered first choice, as the other DOACs have better safety profiles and patient satisfaction. Bleeding is common with warfarin usage and is more likely to be develop in patients who are older (65 years of age and older) and with comorbidities, such as diabetes, recent myocardial infarction, and other chronic conditions (e.g., kidney disease, stroke). If it develops, bleeding can be reversed with vitamin K at a dose of 2.5–10 mg intravenously or orally. Fresh frozen plasma can also be used with elevated prothrombin complex concentrates [5; 30; 31]. Drug interactions are also a concern with warfarin. Another potential complication is warfarin-induced necrosis, which is more likely to occur in patients with a history of heparin-induced thrombocytopenia. If warfarin is used, the dose should be adjusted to reach and maintain a target goal of an international normalized ratio (INR) of 2.5 (range: 2.0–3.0).

Heparin

Intravenous unfractionated heparin has a short half-life and can be reversed with protamine [28]. An initial bolus is given followed by an infusion, during which partial thromboplastin time (PTT) values are monitored. The dosage is based on a weight-based protocol. Although relatively safe to use, the pharmacokinetics of this drug are unpredictable, resulting in the need for close clinical monitoring. However, due to its short half-life, it can quickly be reversed, if needed.

Subcutaneous low-molecular-weight heparin has several advantages, including increased bioavailability and more predictable anticoagulation, as opposed to intravenous unfractionated heparin [28; 32]. There is also decreased incidence of bleeding and potentially better outcomes. Low-molecular-weight heparin is given at a dosage of 1 mg/kg body weight. All heparin products include similar bleeding risk profiles as well as a risk for thrombocytopenia, urticaria, and anaphylaxis. For patients with breakthrough deep vein thrombosis and/or PE during therapeutic warfarin treatment, the ASH suggests using low-molecular-weight heparin over DOAC therapy [27].

Fondaparinux

Fondaparinux is a factor Xa antagonist given subcutaneously in the management of acute PE instead of heparin. Advantages include fixed-dose administration once or twice per day, lack of need for clinical monitoring, and lower risk of thrombocytopenia. The dose is 5 mg for patients who weigh less than 50 kg, 7.5 mg for patients weighing 50–100 kg, and 10 mg for those weighing more than 100 kg. The dose should be adjusted in persons with kidney disease. It is contraindicated for patients with a creatinine clearance less than 30 mL/minute. When used for thromboprophylaxis, some experts recommend a 50% dose reduction or use of low-dose heparin instead [29].

SURGICAL MANAGEMENT

Pulmonary embolectomy is indicated for patients that have high- or intermediate-risk PE with contraindications to thrombolysis; failed thrombolysis or catheter-assisted embolectomy; or hemodynamic shock that is likely to cause death before thrombolysis can take effect [52]. Surgical pulmonary embolectomy is a procedure performed on cardiopulmonary bypass through a midline sternotomy, involving either central or femoral vessel initiation. Management involves moderate hypothermia for better visualization and protection during moments of reduced cardiopulmonary bypass flows. Aortic cross-clamping and cardioplegic arrest are sometimes unnecessary to prevent negative effects on right ventricular recovery [51]. Dual incisions offer improved visualization and better clot extraction. Various methods, such as suction, retrograde perfusion, manual manipulation, or balloon-tipped catheters, can aid clot extraction, but balloon catheters may lead to increased postprocedural complications [51].

SECONDARY PREVENTION

Maintenance anticoagulation for secondary prevention is done for patients who have extensive clot burden or to reduce the risk of new clot formation. There are multiple pharmacotherapeutic options for this phase of treatment, including factor Xa inhibitors (e.g., apixaban), dabigatran, and aspirin. Warfarin and low-molecular-weight heparin are second-line options.

Factor Xa anticoagulants, such as apixaban and rivaroxaban, are the most common first-line option for secondary prevention. Though warfarin was previously used, research has shown a decreased risk for intracranial hemorrhage with factor Xa anticoagulants compared with warfarin. When used for maintenance therapy, the dosage of apixaban is 2.5 mg twice per day; the dosage of rivaroxaban is 10 mg once per day. Cessation of therapy should be considered again after 6 to 12 months [4; 5].

Those with incidental PE, very small clot burdens, and minimal symptoms should likely be treated in an outpatient setting—unless other risk factors are present. However, patients with hemodynamically unstable PE (e.g., extensive clot burden, low blood pressure, abrupt clinical deterioration) often require an intensive care stay.

Aspirin has also been studied for long-term maintenance therapy and is more effective than placebo. However, anticoagulation is typically preferred over aspirin. When anticoagulation therapy is initiated in patients with PE with stable cardiovascular disease who were previously taking aspirin for cardiovascular risk modification, clinicians should consider suspending the aspirin during anticoagulation therapy. Enoxaparin sodium or low-molecular-weight heparin may be used in high-risk cancer patients with recurrent PE [2; 28].

Duration of Pharmacotherapy for Secondary Prevention

How long should anticoagulation therapy continue in patients who have experienced PE?

As noted, the duration of anticoagulation therapy for secondary prevention is dependent on a variety of factors, such as bleeding risk and risk factors for PE, and can range from three months to lifelong therapy [3; 28; 32]. If the patient experienced PE following a transient risk factor (i.e., a provoked event), such as immobilization or recent surgery or trauma, at least three months of treatment is warranted, after which therapy should be reassessed. However, those who have chronic provoked factors for PE, such as active cancer, a hypercoagulable state, or chronic immobility, may benefit from long-term (indefinite) anticoagulation therapy. When creating the treatment plan, the goal is to weigh the benefits of PE and deep vein thrombosis prevention with the risk of anticoagulation events (e.g., bleeding). Risk factors for bleeding include age 65 years or older, frequent falls, alcohol abuse, renal failure, previous stroke, diabetes, and anemia.

For patients who develop PE provoked by a transient risk factor and who have a history of a previous thrombotic event also provoked by a transient risk factor, the ASH guideline panel suggests stopping anticoagulation after completion of the primary treatment phase of therapy [27].

PE IN THE OUTPATIENT SETTING

When possible, patients at assessed low risk for complications (i.e., minimal risk of PE-related death) should be discharged from the hospital and continue to receive treatment at home. Such patients are hemodynamically stable, with have no right heart strain and normal cardiac biomarkers. Most patients with low-risk PE can be treated with an oral anticoagulant or a brief period of low-molecular-weight heparin followed by oral therapy. The presence or absence of comorbidities and proper care and anticoagulation therapy, which can be provided on an outpatient basis, should be noted. Scoring systems have been developed to stratify these patients, including the HESTIA rule (***Table 4***), the PE Severity Index (PESI), and its simplified version (sPESI) (***Table 5***) [33; 34; 35].

The PESI scales identify those with a low risk of 30-day mortality [33]. The criteria used include age, sex, history of cancer, history of chronic pulmonary disease, heart rate, systolic blood pressure, and oxygen saturation [33]. The scales relate the risk stratification score to an associated 30-day mortality and risk of death and can assist in identifying patients who may appropriately be managed at home. The patient's social situation, access to supportive care, and ability to transfer to higher level care should all be considered before shifting to outpatient management.

Anticoagulation options to manage confirmed PE in an outpatient setting include subcutaneous low-molecular-weight heparin, fondaparinux, unfractionated heparin, or DOACs [28; 32; 38; 39]. The treatment duration is generally three to six months [38; 39]. Following the initial three-month period, the decision of whether or not to continue treatment will be made based on continued risk of recurrent thromboembolic balanced against the risks of continued anticoagulation [4; 5; 40].

HESTIA EXCLUSION CRITERIA FOR OUTPATIENT TREATMENT	
Criteria	**Points[a]**
Hemodynamically unstable	1
Thrombolysis or embolectomy needed	1
Active bleeding or high risk of bleeding	1
More than 24 hours on supplemental oxygen needed to maintain oxygen saturation >90%	1
PE diagnosed during anticoagulant treatment	1
Severe pain requiring IV pain medication for more than 24 hours	1
Medical or social reason for hospital treatment for more than 24 hours (e.g., infection, malignancy, no support system)	1
Creatinine clearance of <30 mL/min	1
Severe liver impairment	1
Pregnancy	1
History of heparin-induced thrombocytopenia	1

[a] A score of 1 or more is defined as high risk and rules out outpatient treatment.

Source: [36] *Table 4*

THE ORIGINAL PULMONARY EMBOLISM SEVERITY INDEX (PESI) AND THE SIMPLIFIED PESI (sPESI) CLINICAL RISK SCORES		
Parameter	**PESI**	**sPESI**
Age	Age in years	1 if older than 80 years
Male sex	10	–
Cancer diagnosis	30	1
Chronic heart failure Chronic pulmonary disease	10 10	1
Pulse ≥110 beats per minute	20	1
Systolic blood pressure <100 mm Hg	30	1
Respiratory rate ≥30 breaths per minute	20	–
Temperature <36°C	20	–
Altered mental status	60	–
Arterial oxyhemoglobin saturation <90%	20	1
Risk Stratification (PESI)		
Class I (≤65 points)	Very low 30-day mortality risk (0% to 1.5%)	
Class II (66–85 points)	Low mortality risk (1.7% to 3.5%)	
Class III (86–105 points)	Moderate mortality risk (3.2% to 7.1%)	
Class IV (106–125 points)	High mortality risk (4% to 11.4%)	
Class V (>125 points)	Very high mortality risk (10% to 24.5%)	
sPESI Score		
0 points	30-day mortality risk 1%	
1 or more points	30-day mortality risk 10.9%	

Source: [37; 56; 57] *Table 5*

PE AND COVID-19

Hospitalized patients with advanced COVID-19 may have laboratory signs of a coagulopathy and increased risk for arterial and venous thromboembolic complications, including PE [41; 42; 43]. The pathogenesis is unknown but likely involves some combination of systemic inflammation, endothelial dysfunction, platelet activation, immobility, and stasis of blood flow [43]. The earliest abnormalities are elevated D-dimer levels and mild thrombocytopenia; with disease progression, fibrin degradation products are elevated and prothrombin time becomes prolonged. Laboratory measure of coagulation factors in patients hospitalized with COVID-19 provides a way to track disease severity. The presence of an elevated D-dimer on admission carries a poor prognosis and has been associated with increased risk of requiring mechanical ventilation, intensive care unit admission, and mortality [43; 44]. The most frequently reported complications of COVID-19 coagulopathy are deep venous thrombosis and PE. In a prospective study of 150 critically ill patients from two centers in France, 25 patients developed PE and 3 developed deep vein thrombosis, despite prophylactic anticoagulation [45]. In a report of 184 patients with severe COVID-19 from three centers in the Netherlands, the cumulative incidence of venous thromboembolism was 27%, including PE in 80% of the cases affected [46]. Other centers have reported lower rates. Among 393 patients from New York, venous thromboembolism was diagnosed in only 13 patients (3.3%), 10 of whom were on mechanical ventilation [47]. The National Institutes of Health recommends all hospitalized patients with COVID-19 who experience rapid deterioration of pulmonary, cardiac, or neurological function or sudden, localized loss of peripheral perfusion be evaluated for thromboembolic disease [48].

At present, there are limited data available to inform clinical management around prophylaxis or treatment of venous thromboembolic complications in patients with COVID-19 [41]. One source of interim guidance recommends regularly monitoring hemostatic markers—namely D-dimer, prothrombin time, and platelet count—in all patients presenting with COVID-19 and prophylactic use of low-molecular-weight heparin in all hospitalized patients, unless there are contraindications [43]. The National Institutes of Health recommends that hospitalized, nonpregnant adults with COVID-19 who do not require intensive-level care and have no evidence of venous thromboembolism receive a therapeutic dose of heparin if their D-dimer levels are above the upper normal limit and they require low-flow oxygen, as long as they do not have an increased risk of bleeding [48].

Contraindications for the use of therapeutic anticoagulation in patients with COVID-19 include [48]:

- Platelet count <50 x 10^9/L
- Hemoglobin <8 g/dL
- Need for dual antiplatelet therapy
- Bleeding within the past 30 days that required an emergency department visit or hospitalization
- History of a bleeding disorder or an inherited or active acquired bleeding disorder

Low-molecular-weight heparin is preferred over unfractionated heparin because of its ease of administration and because low-molecular-weight heparin was the predominant form of heparin used in the clinical trials for COVID-19 [48].

In patients without venous thromboembolism who have started treatment with therapeutic doses of heparin, treatment should continue for 14 days or until they are transferred to intensive care or discharged from the hospital, whichever comes first. A prophylactic dose of heparin is also recommended for patients who do not meet the criteria for receiving therapeutic heparin or are not receiving a therapeutic dose of heparin for other reasons, unless a contraindication exists [48].

For those patients who develop a PE in the setting of a COVID-19 infection, about 50% will report persistent fatigue, reduced exercise tolerance, and dyspnea [14; 23]. Of these patients, one-half will also have signs of right ventricular dysfunction on echocardiogram after the diagnosis is made, referred to as post-PE syndrome. This further leads to dyspnea on exertion, damage to the venous valves in the leg, prolonged lower extremity swelling and aching, venous ulcers, and impaired quality of life.

CONCLUSION

PE is a common cause of acute-onset breathlessness and chest pain, often confused for many other diagnoses. It should remain on one's clinical differential due to the fact that it can be life-threatening and is treatable if caught and managed early. A variety of treatment options are at the forefront for ensuring that patients are given the best possible outcome.

Customer Information/Evaluation insert located between pages 16–17.

COURSE #97471 — 5 CONTACT HOURS RELEASE DATE: 11/01/20 EXPIRATION DATE: 01/31/24

Human Trafficking and Exploitation: The Texas Requirement

This course has been approved by the Texas Health and Human Services Commission (HHSC) to meet the requirement for human trafficking training.

Audience

This course is designed for Texas nurses, physicians, social workers, pharmacy professionals, therapists, mental health counselors, and other members of the interdisciplinary team who may intervene in suspected cases of human trafficking and/or exploitation.

Course Objective

As human trafficking becomes an increasingly more common problem in the United States, healthcare and mental health professionals will require knowledge of human trafficking patterns, the health and mental health needs of human trafficking victims, and successful interventions for victims. The purpose of this course is to increase the level of awareness and knowledge about human trafficking and exploitation so health and mental health professionals can identify and intervene in cases of exploitation.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define human trafficking.
2. Identify the forms of human trafficking.
3. Identify individual, family/relationship, community/organizational, and societal/cultural that contribute to human trafficking.
4. Analyze the trafficking experience, including how traffickers recruit and the financial implications of trafficking.
5. Explain the psychologic, health, and social consequences of human trafficking.
6. Utilize interviewing strategies to assess and identify victims and promote the ethical treatment of trafficking victims.
7. Outline the healthcare professional's responsibilities in identifying and assisting survivors of trafficking, including best practices for referral and collaboration.

Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planner

Jane C. Norman, RN, MSN, CNE, PhD

Senior Director of Development and Academic Affairs

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Division Planner/Director Disclosure

The division planner and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Special Approvals

This course has been approved by the Texas Health and Human Services Commission (HHSC) to meet the requirement for human trafficking training.

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Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the study questions and course material for better application to your daily practice.

INTRODUCTION

Human trafficking is not a new social problem; it has always existed. Trafficking has recently received increased attention as a result of awareness and outreach efforts. It has garnered attention from feminists, religious conservatives, labor activists, immigration specialists, and the mental health professions [1]. This course will provide a basic overview of human trafficking (e.g., the scope, definitions and frameworks, contributing factors, different forms). The course will attempt to provide practitioners a glimpse of the lives of human trafficking victims, including the physical, psychological, social, and sexual abuse that human trafficking victims experience and the types of control tactics that perpetrators use. Specific interventions and responses will be covered, including mental health, social services, educational, prevention, and legal efforts. Finally, for practitioners who work with human trafficking victims, the emotional toil that it takes on practitioners as well as the importance of self-care will be discussed. Practitioners will be encouraged to view films and documentaries about human trafficking, as this is one way to "enter the lives" of human trafficking victims and better understand the dynamics of the complex world of human trafficking.

BACKGROUND

Because human trafficking is a complex issue, it is difficult to determine the scope of the problem. Many scholars and researchers believe that published estimates are just educated guesses. On a global level, the International Labour Organization has estimated that there were 49.6 million people living in modern slavery in 2021, 27.6 million in forced labor, and 22 million in forced marriage [2]. The estimates for the United States are not totally clear, but there were approximately 78,000 human trafficking victims reported to the U.S. State Department in 2016; only an estimated 0.2% are rescued [3]. According to Polaris, which founded and runs the National Human Trafficking Hotline, there have been a total of 40,200 cases of human trafficking reported since 2007 [3]. According to statistics from the U.S. Department of Justice, the number of persons prosecuted for human trafficking increased from 729 in 2011 to 1,343 in 2020, an 84% increase [4].

A wide range of laws have been established to protect human trafficking victims and to prosecute perpetrators. A general knowledge of these laws is helpful when caring for victims and seeking appropriate social services. The Trafficking Victims Protection Act (TVPA) was enacted in 2000 and reauthorized in 2003, 2005, 2008, 2013, 2018, and 2022 by the Trafficking Victims Protection Reauthorization Acts [5]. It emphasizes the three Ps: prevention, protection, and prosecution [5]. The prevention component consists of training and awareness; the protection dimension gives trafficked victims the ability to receive services using federal funds like other refugees; and the prosecution component focuses on laws and policies for the prosecution of traffickers.

Because victims of trafficking are often viewed as criminals, this law states that victims of severe trafficking should not be penalized for any illegal behaviors or acts they engaged in as a result of being trafficked, including entering the United States with false documents or no documentation or working without appropriate paperwork [6]. This law also allows T Nonimmigrant Status (T visas) to be granted to victims of trafficking so they may remain in the United States with the purpose of collaborating with the federal authorities to prosecute the perpetrators. During this time, victims are offered a range of benefits and services, including access to the Witness Protection Program [6]. After three years, victims can apply for permanent resident status [7].

One of the criticisms of the Act is that it places the burden of demonstrating innocence and coercion on the victim [8]. The Act also fails to recognize the complex dynamics of human trafficking. For example, it focuses more on sex trafficking versus other forms [9]. Many victims have been abused and terrorized by the perpetrators, who they must now provide information and evidence against to stay in the country. Victims are continually fearful that they will be deported [8].

Victims who are of minor age are eligible for Unaccompanied Refugee Minors programs, the Children's Health Insurance program, and Temporary Assistance to Needy Families [10]. Furthermore, victims between 16 and 24 years of age are eligible for work permits and can apply for the Job Corps program [10]. It is important to remember that the key to this law is that the victim must have experienced a "severe form" of trafficking and must be willing to assist in the apprehension and prosecution of the perpetrator to receive services [11].

DEFINITIONS OF HUMAN TRAFFICKING

How does the United Nations define human trafficking?

The United Nations defines human trafficking as [12]:

> The recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation or the prostitution or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude, or the removal of organs.

In essence, this definition involves three elements: the transport of the person, the force or coercion of the victim, and the abuse and exploitation [13]. The United Nations Office on Drugs and Crime divides the definition of human trafficking into three sections: the act, means, and purpose [14]. The act, or what is done, generally refers to activities such as recruitment, transportation, transfer, harboring, or receipt of persons. The means of trafficking consists of threats or use of force, coercion, abduction, fraud, deception, abuse of power or vulnerability, or giving payments or benefits to a person in control of the victim. Finally, these acts are carried out for the purpose of exploitation, which includes prostitution, sexual exploitation, forced labor, slavery or forced servitude, and the removal of organs [14].

The TVPA defines human trafficking to include both sex trafficking and labor trafficking [15]:

> Sex trafficking is the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purposes of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age. Labor trafficking is the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purposes of subjection to involuntary servitude, peonage, debt bondage, or slavery. A victim need not be physically transported from one location to another for the crime to fall within this definition.

In many cases, women and children are considered the typical victims of human trafficking. Hart posits that women are more vulnerable to trafficking due to the lack of social safety nets in many developing countries [16]. Coupled with women's subordinate social status in many cultures, this leads to the "feminization of poverty." Although the social conditions may make women and children more vulnerable to human trafficking, the reality is that men are also victims of human trafficking.

Overall, the definition of human trafficking is ambiguous because of the many intersections with other issues (e.g., sexual abuse, domestic violence, forced marriage, forced labor) [17]. It occurs both domestically and internationally, but is primarily a hidden problem. This makes research efforts, the prosecution of perpetrators, and policy and community efforts to protect victims even more challenging [17]. It is vital to remember that trafficking, as defined by U.S. law, does not require crossing international or even state borders. The transport of victims from one locale to another is not a necessary component of determining whether human trafficking has occurred.

LIMITATIONS OF DATA ON HUMAN TRAFFICKING

Although the United Nations definitions are used in this course, scholars, practitioners, researchers, and policy makers have not come to a consensus definition of human trafficking. Consequently, terms such as sexual slavery, human smuggling, and modern-day slavery have all been used [18]. When the term human trafficking is utilized, it often has connotations of sexual exploitation affecting mainly women and girls, the most visible victims, but this is not accurate [18]. This perspective is partially attributable to the large number of religious and feminist organizations who have worked to eradicate non-consensual sex work [19]. This lack of consensus definition also raises questions about the study population in the research. The involved parties (i.e., the trafficker, those who are trafficked, and the networks) are continually changing in time and space [20].

Defining these terms is essential because it will ultimately influence responses to human trafficking. As stated, all social problems are competing for attention and resources, and the response is influenced by how the social problem is defined and portrayed [21]. Ultimately, the lack of a consensus definition is one of the reasons studying human trafficking has been a challenge and that research yields unreliable prevalence estimates.

Another reason human trafficking has been a difficult topic to research is the hidden and invisible nature of its victims and perpetrators. This makes it difficult for researchers to use traditional sampling methods. Even if trafficked victims are identified, perpetrators can move them to new locations [22]. If and when researchers access this hidden population, victims are often reluctant to talk due to fear, shame, and the stigma associated with their experiences. Consequently, much of what has been studied has relied on interviews with professionals (e.g., lawyers, advocates, police/law enforcement, and other service providers), which has led to recommendations that are not based on firsthand accounts [23].

A host of ethical issues also arise for those conducting research in this area. Protecting study participants' identities is paramount, and consequently, study participants signing informed consent forms, which are often required by institutional review boards, becomes complicated. Understandably, victims and perpetrators often will not want to sign forms using their real names for fear of deportation, arrest, and/or reprisals [22].

FORMS OF TRAFFICKING

The social realities of victims of human trafficking are difficult to comprehend, and some may wonder why victims remain silent and comply with their traffickers. The Silence Compliance Model was created to explore the factors that promote victims' seeming willingness to comply with their traffickers' demands [24]. This model has three categories: coercion, collusion, and contrition. Victims are coerced, brutalized, and threatened, and basic necessities of life are withheld from them. Methods of psychological coercion include isolation, induced exhaustion, threats, degradation, and monopolizing perception [25]. This serves to silence victims and create a sense of helplessness. By isolating and controlling victims' movements and limiting their exposure to the outside world, traffickers have complete monopoly of their attention and perception of reality [25]. Victims are then forced to collude with the traffickers as a result of their relative isolation, fear, false sense of belonging, and complete dependence on the trafficker. Finally, victims feel contrite, ashamed, stigmatized, and remorseful of the things they have been made to do [24].

Another model, the Action-Means-Purpose (AMP) Model, is a device used to illustrate and articulate the federal definition of a "victim of severe forms of trafficking in persons" [26]. The Action category consists of the actions a perpetrator takes to induce, recruit, harbor, transport, provide, or obtain a victim. The Means of force, fraud, or coercion are used for the ultimate Purpose of commercial sex or labor/services trafficking [26].

It is important to remember that human trafficking is not human smuggling. Human smuggling involves an individual being brought into a country through illegal means and is voluntary. The individual has provided some remuneration to another individual or party to accomplish this goal [7].

SEX TRAFFICKING

What is domestic minor sex trafficking?

The TVPA of 2000 is a U.S. federal statute passed by Congress to address the issue of human trafficking and offers protection for human trafficking victims [15]. This statute defines sex trafficking as, "the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act" [15]. A commercial sex act is, "any sex act on account of which anything of value is given to or received by any person" [15]. In other words, it usually involves the illegal transport of humans into another country to be exploited in a sexual manner for financial gain [27]. However, it does not always involve the transport of victims from one region to another; such cases are referred to as "internal trafficking" [28]. Victims of sex trafficking could be forced into prostitution, stripping, pornography, escort services, and other sexual services [29]. Victims may be adult women or men or children, although there is a higher prevalence of women and girls. The term "domestic minor sex trafficking" has become a popular term used to connote the buying, selling, and/or trading of children younger than 18 years of age for sexual services within the country, not internationally [29; 30]. An element of force, fraud, or coercion is not necessary, as the victims are children and inherently vulnerable [30]. In the United States, the children most vulnerable to domestic minor sex trafficking are those who are homeless, abused, runaways, and/or in child protective services [29].

Although controversial, it is said that sex trafficking victims differ from consensual sex work in that sex trafficking victims are forced to involuntarily perform sexual services and are often not paid for their "work." Sex trafficking involves the use of force and coercion and can encompass other forms of criminal sexual activities, including forced erotic dancing, "mail-order brides," and pornography [28]. On the other hand, individuals involved in consensual sex work make a decision to provide sex services for a fee. The decision to enter sex work does not eliminate the possibility of being a victim of trafficking if one is held against his/her will through physical and/or psychological abuse [4]. It is also important to remember that this does not necessarily mean sex work is a choice these individuals would have made if other options were available or that they have a choice in selecting their sexual partners and/or sexual activities [31].

BONDED LABOR/FORCED LABOR

The United Nations has defined debt bondage as [32]:

> The status or condition arising from a pledge by a debtor of his personal services or of those of a person under his control as security for a debt, if the value of those services as reasonably assessed is not applied towards the liquidation of the debt or the length and nature of those services are not respectively limited and defined.

Essentially, because the individual does not have money as collateral for the debt owed, the individual pledges his/her labor or, in some cases, the labor of a child or another individual for an unspecified amount of time [33]. These individuals may be transported or trafficked into another country for the purpose of forced labor.

In many cases of bonded labor, the initial loan may be welcomed by the individual. However, the victims do not realize that with the low wages, unspoken high interest rates and other continually accruing fees, and the perpetrator's manipulation of the "accounts," laborers can never repay the loans. Some estimate that half of all persons in forced labor are bonded laborers. The majority of bonded labor cases occur in India, Bangladesh, and Pakistan [34]. Some families find themselves in a cycle of poverty as the debt cannot be paid off and is passed down from generation to generation [33]. Bonded labor can involve laborers in brick kilns, mines, stone quarries, looming factories, agricultural farms, and other manufacturing factories [33]. In the United States, individuals may be trafficked to work long hours in garment factories, restaurants, and other manufacturing sectors. Frequently, the employer/captor will take away victims' identifications, monitor their movements, socially isolate them, and/or threaten deportation if they do not comply [35]. Migrant workers are at high risk of forced labor [4].

In the United States, forced labor is predominantly found in five sectors [35]:

- Prostitution and sex industry (46%)
- Domestic servitude (27%)
- Agriculture (10%)
- Sweatshops and factories (5%)
- Restaurant and hotel work (4%)

It is speculated that most of the forced labor occurs in California, Florida, New York, and Texas, all major routes for international travel [35].

Domestic servitude refers to a category of domestic workers (usually female) who work in forced labor as servants, housekeepers, maids, and/or caregivers, often in private homes. In some cases, young women are lured with the promise of a good education and work, and when they arrive in the United States, they are exploited economically, physically, and/or sexually. Their passports or identification papers are taken away, and they are told they have to pay off the debt incurred for their travel, processing fees, and any other bogus expenses. Because they do not speak English, they find they have no other recourse but to endure exploitative working conditions [36]. Unfortunately, as in many sectors of forced labor, there are no regulations to monitor the conditions under which domestic servants operate [35].

CHILD LABOR

Child labor can be viewed as a specific form of bonded labor or forced labor. However, not all child laborers have been trafficked. Child labor is defined by International Labour Organization (ILO) as economic labor performed by a child younger than 15 years of age or hazardous labor done by a child 18 years of age or younger. Child labor is deeply rooted in poverty and the infrastructure and political stability of the country as well as market forces [37]. The ILO estimates that there were 160 million child laborers in the world in 2020 (63 million girls and 97 million boys) [38]. This accounts for nearly one in ten of all children worldwide [38]. Between 2000 and 2020 there was a nearly 35% decrease in the number of children in child labor. The reduction was greater for girls than for boys . The number of children in child labor has increased from 2008 to 2020 in sub-Saharan Africa (from 65.1 million to 86.6 million), while it has declined in other parts of the world (e.g., Asia/the Pacific, Latin America/the Caribbean) [38].

The definition of child labor is controversial because the definitions for "work" and "childhood" are ambiguous and often culturally defined [39]. On a conceptual level, work may be beneficial for the socialization and educational processes of children [39; 40]. So, it is important to differentiate between child work and child labor. Child work has been defined as activities that are supervised by an adult and that promote the development and growth of the child, while child labor does not benefit the child [37]. Many definitions of child labor create a dichotomy whereby child work is considered not harmful while child labor has negative emotional, intellectual, and social consequences [41]. Work that is exploitative for children has been defined as working long hours at a young age, work that is poorly compensated, and work that produces physical, social, and psychological stress that will hamper development, access to education, and self-esteem [42]. The ILO adds that child labor is work that "interferes with their schooling by: depriving them of the opportunity to attend school; obliging them to leave school prematurely; or requiring them to attempt to combine school attendance with excessively long and heavy work" [40].

It is important to remember that child labor occurs in the United States. Runaway and homeless youths are at greatest risk, often lured by promises of work and housing [43]. The Polaris Project found that the top three forms of child labor trafficking in the United States were begging, peddling, and traveling sales crews [43].

CHILD CONSCRIPTION

In some cases of trafficking, children are kidnapped and trafficked to serve as soldiers. Other times, children are coerced by a narrative indicating they will be serving a higher purpose and avenge the deaths of family and friends; this is known as comradeship [44; 45]. Some children are actively recruited and may be promised a small salary to "voluntarily" join.

It is estimated that at any one time up to 300,000 children younger than 18 years of age are serving as child soldiers [46; 47]. Traffickers prefer to recruit children to serve as soldiers because they are inexpensive and more easily molded and shaped to comply and obey without question [48]. It can be difficult to comprehend the atrocities that these children witness and experience [49; 50].

FACTORS THAT CONTRIBUTE TO VULNERABILITY TO HUMAN TRAFFICKING

INDIVIDUAL

A variety of individual level factors may predispose an individual to human trafficking victimization. A history of physical, sexual, or emotional abuse and/or of witnessing violence in the home has been identified at increased rates among trafficking victims. Other possible risk factors include adherence to rigid gender roles, acceptance of norms supporting sexual exploitation of women and children, overestimation of problem behavior in peers/others, lack of trafficking awareness, and substance abuse [51].

Adverse Childhood Experiences

In more recent years, research has focused on the impact of adverse childhood experiences (ACEs) in general. ACEs are defined as potentially traumatic experiences that affect an individual during childhood (before 18 years of age) and increase the risk for future health and mental health problems (including increased engagement in risky behaviors) as adults [52]. Abuse and neglect during childhood are clear ACEs, but other examples include witnessing family or community violence; experiencing a family member attempting or completing suicide; parental divorce; parental or guardian substance abuse; and parental incarceration [52].

One study found that youths with human trafficking reports were significantly more likely to have experienced ACEs [53]. Specifically, sexual abuse was the strongest predictor of human trafficking. Girls with a history of sexual abuse were 2.52 times more likely to experience human trafficking, and boys who had been victims of sexual abuse were 8.21 times more likely to be trafficked.

Poverty and Economic Disenfranchisement

Poverty and incessant economic stressors caused by civil wars, natural disasters, and collapses of government systems all contribute to human trafficking [16; 30; 54]. In one study, the odds of being trafficked were nine times greater for those who felt extremely hopeless about upward mobility compared with those with lower levels of hopelessness [54].

RELATIONSHIP/FAMILY

Families marked by instability (e.g., domestic violence, child abuse, continual unemployment) are also at higher risk of having a member trafficked [30]. In addition, families entrenched in deep poverty may feel they have no other recourse but to sell a child or may be more easily lured with promises of money and a better future [54; 55; 56].

COMMUNITY/INSTITUTIONAL

How does digital technology play a role in human trafficking?

Community factors (such as high social disorganization characterized by violence, unemployment, and high crime) contribute to higher risk of trafficking [30].

The rampant use of digital technology, such as the Internet, greatly facilitates sex trafficking. The relative anonymity of online contact can empower traffickers to recruit or sell victims. Graphic images of women and children engaged in sexual acts can be easily disseminated over the Internet [57]. Traffickers may employ the Internet for advertising, marketing to those interested in making pornography [57]. In addition, social media sites such as Facebook, Craigslist, and Instagram have been used as a means of facilitating trafficking (e.g., by connecting and grooming potential victims) [58; 59; 60]. Newsgroups offer opportunities for those interested in locating women and children for sexual exploitation.

In a 2013 qualitative study, smartphones were found to be integral in the business of trafficking [58]. Researchers indicated the phones were used "to maintain contact with each other, in order to facilitate the business 'transactions' and stay in touch with transnational 'partners' and other traffickers who remained in the country of origin" [58; 59].

SOCIETAL/CULTURAL

Globalization

Human trafficking has been called one of the "darkest sides of globalization" [61]. Globalization is the term used to describe the interconnectedness of countries and nations, which facilitates easy communication, exchange of ideas, and flow of goods, capital, and services [61]. Crimes such as human trafficking are affected by globalization just as legitimate businesses are [62]. Furthermore, the ideals of Western capitalism may reinforce human trafficking as a business or industry, with its emphasis on the free market and the flow of goods and services across international borders [62].

Globalization has also created the need for cheaper labor [34; 63]. A study involving 160 countries examined the effects of globalization and human trafficking trends [64]. Researchers found a positive relationship between globalization and trafficking for forced labor, sex work, and debt bondage.

Corruption

Human trafficking cannot occur without the existence of corruption within existing infrastructures. Public officials, police officers, and local leaders in many developing countries have been known to take bribes to provide protection to parties involved in various aspects of human trafficking [61; 64; 65].

Racialized Sexual Stereotypes

Race and ethnicity have been inextricably linked to sexual violence and victimization. Myths regarding sexuality in certain cultures or racial fetishization may affect trafficking patterns. For example, there is an over-representation of Asian women on American Internet pornography sites in part due to popular myths sexualizing, eroticizing, and exoticizing Asian women. This has translated into trafficking, as traffickers respond to the demand for young Asian women and girls in part fueled by these stereotypes of exotic, docile, submissive, and eager-to-please Asian women [36]. These stereotypes devalue and dehumanize people, which is the underlying core of human trafficking. This contributes to the acceptability of the exploitation of individuals, particularly members of marginalized groups [66].

These racial stereotypes go beyond simply framing the victims in a particular manner [67]. They raise implicit questions regarding how the powers of state are depicted. In other words, the patriarchal attitudes of certain countries lead to "bad" or "backward" cultural practices or ways of being that then cause trafficking—setting up a dichotomy of the "West" and "others" [67].

Culture

Although many are careful in linking cultural factors to the etiology of human trafficking for fear of imposing judgment on a particular culture, many maintain that cultural ideologies that tolerate sexual trafficking, bonded labor, and child labor may be a stronger factor than poverty in predicting trafficking rates [36; 42]. For example, some cultures emphasize collectivism and prioritizing the needs of the family and group first before the needs of the individual. Some children may feel they have to sacrifice themselves for their family when traffickers promise money [36]. Traffickers also know that they can threaten to hurt victims' families to keep them from escaping [36].

Furthermore, in many cultures, boys are more highly valued than girls, and as a result, girls are considered more dispensable [36]. Sons are considered the family's social security, staying with the family while daughters marry into other families. Therefore, girls may be more likely to be sold into slavery than boys.

Child labor is also inextricably tied to cultural factors. In India, for example, child labor is common because it is believed that children in the lower levels of the caste system (i.e., the "untouchables") should be socialized early to understand their position in society [42]. It has been observed that when traditional cultural and societal norms about women's roles were relaxed in some European countries and more women entered the labor force, child labor decreased [42]. Ultimately, it is difficult to unravel the effects of poverty and culture because the pressures of poverty can lead families to use tradition as a justification to sacrifice young men, women, and children [42].

Ultimately, the conversation about human trafficking is complex, and to attempt to isolate the causes is beyond challenging. Multiple factors have been suggested as possibly predicting human trafficking, including macroeconomic factors (e.g., gross domestic product per capita), unemployment rates, female inequality, cultural oppression, and lack of protection of women's rights [68; 69]. In one study, ease of land access to the destination country appeared to be a powerful predictor in terms of the number of individuals trafficked [68].

TRAFFICKERS: AN OVERVIEW

What are methods of recruitment used by human traffickers?

Much attention has been focused on the victims of trafficking; however, it is important to also understand the perpetrators.

It has been suggested human traffickers employ five general strategies to recruit and traffic victims [6; 70; 71; 72]:

- Kidnapping: Traffickers may kidnap their victims. They may lure them with food or treats or take them by force. Victims with few if any social ties are highly vulnerable, as no one will miss them or report their disappearance.
- Targeting poor families: Traffickers may convince families to sell their children (often daughters). Because many families in developing countries live in abject poverty, traffickers will stress to victims' families how the money will help them to survive. Other traffickers may tell families that selling their daughter will provide her with more promising opportunities.
- Developing a false romantic relationship with victim: A tactic often used with young girls, perpetrators pose as boyfriends by romancing victims, buying gifts, and proclaiming their love. Victims have a difficult time believing that their boyfriends would hurt or deceive them, making them easy targets for trafficking.
- Fake storefronts: Some employment, modeling, or marriage agencies are fronts for illegal trafficking operations. A potential victim might be lured with the promise of employment, a lucrative modeling contract, or an arranged marriage in the United States. After victims have been lured in, traffickers come to assess their "product." Perpetrators may be family members or friends.
- Legal storefronts: Some legal businesses in the tourism, entertainment, and leisure industries integrate trafficking activities into their business structure.

Recruiting local sex workers: Traffickers might purchase sex workers working in local night clubs from brothel owners or simply lure sex workers by promising them a more affluent future. These trafficked sex workers may later recruit younger victims.

IMPACT ON VICTIMS/SURVIVORS

HEALTH CONSEQUENCES

What are common physical findings in trafficked women?

In studies of trafficked women, headaches, fatigue, dizziness, back pain, pelvic pain, stomach pain, sexually transmitted infections (STIs), unwanted pregnancies, and gynecologic infections were common, generally the result of continual physical, psychological, and sexual abuse [30; 73]. Victims of labor trafficking also experience health issues related to the type of work, workplace conditions, malnutrition, and violence [74]. It is important to remember that some of these somatic complaints, such as headaches, fatigue, and gastrointestinal problems, may be underlying symptoms of anxiety, depression, and stress [73]. Some cultural groups might not use the terms "depression," "sad," or "anxious," but may use metaphors and somatic symptoms to describe their pain, all of which are embedded within cultural ideologies. The most common culture-based idioms of distress are somatic symptoms. Some groups tend not to psychologize emotional problems; instead, they experience psychological conflicts as bodily sensations (e.g., headaches, bodily aches, gastrointestinal problems, and dizziness).

Using an in-depth, direct interview survey designed to explore each stage of the trafficking experience, a multi-country European study identified a range of aversive health, sexual, and reproductive consequences common among women and adolescent victims of human trafficking [75]:

- Pre-departure stage: All victims reported having had limited knowledge of the health implications of having sex with strangers, and only 1 in 25 felt well-informed regarding the risks of acquiring HIV or other STIs.
- Travel and transit stage: Half of those interviewed reported having been confined, beaten, and/or raped during the journey.
- Destination stage: A large majority reported having been "intentionally hurt" (as evidenced by contusions, lacerations, loss of consciousness, and signs of head trauma); subjected to solitary confinement and deprived of human contact and adequate food and nutrition; subject to a variety of physical ailments, including headache, fever, undiagnosed pelvic pain, urinary tract infection, STIs, rash/scabies, and oral/dental health issues. All had experienced repeated sexual abuse or coercion, and 1 in 4 reported at least one unintended pregnancy (often involving negative outcomes of abortions performed in unsafe and unhealthy conditions).

Child and Adolescent Victims

Among child victims of human trafficking, healthy growth and development is especially problematic. Malnourishment and poor hygiene often lead to delayed bone growth, poorly formed teeth, and early dental caries [76]. The intense nature of child labor also has severe negative physical and health consequences.

Under normal circumstances, young children are still developing physically; however, such adverse conditions can halt their development. The lungs of adolescent boys typically experience the most rapid growth around 13 to 17 years of age; working in conditions characterized by excessive toxic dust or unclean air makes them more vulnerable to developing silicosis and fibrosis [77]. In the United States, young children participating in agricultural work are at risk of the major traumas associated with farm work, such as injuries caused by tractors or falling from heights, in addition to those injuries associated with repetitive stress and exposure to toxins. Children have thinner layers of epidermis, which make them more vulnerable to the toxicity of pesticides, and this can ultimately increase their risks for certain cancers [77]. Children working in gold mines do intensive digging, lifting, and transporting and mix mercury with the crushed ore, often with their bare hands. Mercury toxicity can lead to neurologic symptoms such as loss of vision, tremors, and memory loss [78].

DENTAL CONSEQUENCES

Victims may present with dental trauma and loss of teeth from violent acts. Injuries to the face and mouth area are common in abuse cases, and the potential for tooth involvement is high. Other dental problems arise as well, including infectious complications due to HIV, and even oral cancers or gingival disease due to substance use or poor access to dental care [79].

SEXUAL/REPRODUCTIVE HEALTH CONSEQUENCES

In the context of forced sex work among trafficked victims, safeguards against infection (e.g., regular condom use), early diagnosis, and adequate antimicrobial treatment are inconsistently employed or absent entirely [75]. Consequently, in addition to unwanted pregnancy, the risk for pelvic inflammatory disease and subsequent infertility is relatively high. Moreover, the relationship between forced sex work and HIV infection is stronger when sexual violence is involved. Women who are forced into sex work are 11 times more likely to become HIV-infected than women who engage in consensual sex work [80]. Sexual violence may increase the transmission risk as a result of open abrasions and injuries to the vagina. Furthermore, sexual violence can negatively impact self-esteem, which could then deter victims from advocating more strongly for condom use [80].

EVIDENCE-BASED PRACTICE RECOMMENDATION

The British Association for Sexual Health and HIV has identified trafficked women/commercial sex workers as a group vulnerable to sexual violence. Inquiries about such vulnerabilities will help to identify those in need of additional support and help to facilitate appropriate referrals to mental health services, general practitioners, and support agencies. Access to interpreter and advocacy services may be helpful.

(https://www.bashhguidelines.org/media/1079/4450.pdf. Last accessed January 25, 2024.)

Level of Evidence: Expert Opinion/Consensus Statement

PSYCHOLOGICAL AND MENTAL HEALTH CONSEQUENCES

Victims of trafficking experience a host of psychological, mental health, and emotional distress. Depression, suicidal ideation, substance use, and anxiety are typically cited mental health problems [30]. Post-traumatic stress disorder (PTSD) is also common given the trauma many victims experience, including physical and/or sexual violence and abuse; victims forced into sex work experience continual, daily sexual assault [81].

In a study of 192 European women who were trafficked but who managed to escape, the overwhelming majority (95%) disclosed that they experienced physical and sexual violence during the time of their trafficked experience [73]. More than 90% reported sexual abuse, and 76% reported physical abuse.

Trafficked victims experience fear from the start of their capture through the transit phase and after they arrive at their destination. During the transit stage, many victims experience dangerous border crossings, risky types of transports, injury, beatings, and sexual assault [75]. Upon arrival to their destination, many trafficking victims have been socially isolated, held in confinement, and deprived of food [82]. All sense of security is stripped from them—their personal possessions, identity papers, passports, visas, and other documents are taken [75; 82]. The continual fear for their personal safety and their families' safety and the perpetual threats of deportation ultimately breed a sense of loss of control and learned helplessness. It is not surprising that depression, anxiety, and PTSD are common symptoms experienced by trafficked victims.

In a study of 164 survivors of human trafficking who returned to Nepal, the authors examined the extent to which they experienced PTSD, depression, and anxiety [83]. All of the survivors experienced some level of these disorders, but the survivors who were trafficked for sex experienced higher levels of depression and PTSD compared to those who were not trafficked for sex. In a study with Moldovan survivors of human trafficking, researchers found that six months after their return, 54% had a diagnosable mental health issue. Specifically, 35.8% met the diagnostic criteria for PTSD, 12.5% met the criteria for major depression, and 5.8% were diagnosed with an anxiety disorder [84].

There is also some evidence that trafficked victims may experience complex PTSD, a type of PTSD that involves an acute change of the victims' sense of self, their relationship with others, and their relationship with God or a higher being [85]. These persons direct anger inwardly (toward themselves) as well as toward their perpetrators, which results in a loss of faith in themselves and the world [82; 85; 86]. Perhaps due to self-directed anger and shame, some will engage in risky sexual behaviors, self-harm, and substance abuse. Some victims also have difficulty managing and expressing how they are feeling, while others experience dissociation [82].

Substance abuse is also common among victims. In interviews, trafficked women discussed how traffickers forced them to use substances like drugs and/or alcohol so they could work longer hours, take on more clients, and/or perform sexual acts that they could not normally perform [75]. Other victims used substances as a means to cope with their situations. Trafficked individuals who are gender and/or sexual minorities report shame, confusion, and sexual identity issues if forced into heterosexual relationships [86].

Children forced into labor experience grueling hours and are frequently beaten by their captors. Underage victims of domestic sex trafficking fluctuate through a range of emotions, including despair, shame, guilt, hopelessness, anxiety, and fear [87]. Depending upon the level of trauma, some engage in self-destructive behaviors like self-mutilation or suicide attempts. For some, their ambivalence toward the perpetrators may be confusing. On the one hand, they want to escape the abuse, yet simultaneously, they may have a sort of traumatic bond with the perpetrators [87].

Children forced into conscription will also experience a host of psychological symptoms. In a study comparing former Nepalese child soldiers and children who were never conscripted, former child soldiers experienced higher levels of depression, anxiety, PTSD, psychological difficulties, and functional impairments [88]. In another study of former child soldiers from the Congo and Uganda, one-third met the criteria for PTSD [49]. The researchers found there was a relationship between greater levels of PTSD symptoms and higher levels of feelings of revenge and lower levels of openness to reconciliation [49]. In-depth narrative interviews of former child soldiers from northern Uganda found that the children spoke of the violence and atrocities they witnessed without any emotion, as if they had removed themselves from their experiences [89]. This speaks to how the victims have to numb themselves psychologically in order to cope. The researchers also found that the children who lost their mothers were more traumatized by this experience than by the violence they witnessed as soldiers.

Some have argued that the diagnostic criteria of PTSD may not be easily applied to those from different cultures. As a result, it is important to assess for other psychiatric disorders, such as depression. Japan, for example, never used the PTSD diagnosis prior to 1995, despite the fact that they have a large and intricate mental health system [90]. Ultimately, PTSD cannot be universally applied to every culture and for every humanitarian crisis; therefore, if a human trafficking victim does not necessarily fall within the *Diagnostic and Statistical Manual of Mental Disorders* criteria for PTSD, one cannot necessarily conclude that they have not experienced trauma or are not traumatized [90].

SOCIAL CONSEQUENCES AND QUALITY OF LIFE

When rescued and attempting to reintegrate into their communities, victims of human trafficking often experience stigma, ostracism, and marginalization [88; 91]. For example, in Nepal, community members perceived returning child soldiers who had performed acts such as carrying dead bodies or coed sleeping as in violation of Hindu cultural norms [88]. One documentary following former child soldiers living in a refugee camp in northern Uganda found that preconceived notions and myths about children soldiers often led to ridicule and ostracism after they were liberated from the army and returned home.

However, girls who were recruited as soldiers, who were forced to have sex, or who return with children appear to be the most marginalized group [92]. In a qualitative study of former girl soldiers in Sierra Leone, researchers found that, compared to returning boy soldiers, girls were perceived to have violated gender norms and values about sexuality. Although psychologically and developmentally they were still children, the community perceived and treated them as "damaged" or "unclean" women. Their communities were not able to re-integrate them, despite the victimization they experienced. These girls lacked voice and experienced shame, marginalization, poverty, and powerlessness upon their return [92]. In a study of former child soldiers in Uganda, the children reported having difficulty finding jobs or getting married when they returned home. Girls who had been raped were stigmatized and made to feel unwelcome in their communities. Others stated that their community perceived them as murderers [50].

IDENTIFICATION AND ASSESSMENT

INTERACTION WITH VICTIMS

Healthcare providers are often the most likely to encounter a victim of human trafficking under circumstances that provide an opportunity to intervene, and victims may be encountered in most mental health and healthcare venues. One study estimated that 30% to 87.8% of victims accessed medical services at some point during their trafficking [93]. Survivors may seek care in hospital emergency rooms, at local mental health authorities, urgent care facilities, family planning clinics, or outpatient medical settings for a variety of issues, including sexually transmitted infections, pregnancy, depression (including suicidality), injuries resulting from assault, substance abuse-related issues, and PTSD [94]. Because medical and dental appointments may allow for more privacy than a victim's other encounters, they may represent a unique opportunity for healthcare providers to intervene.

Yet, many providers lack the training and confidence to identify and assist victims. In a survey of 110 emergency department physicians, nurses, and physician assistants, the majority (76%) reported having a knowledge of human trafficking, but only 13% felt equipped to identify a trafficking victim and only 22% were confident in their ability to provide satisfactory care for such patients [95]. Less than 3% had ever received any training on this topic. In a separate survey of healthcare and social service providers, only 37% had ever received training on identification of trafficking victims [96]. This lack of healthcare provider knowledge is the root of some victim's reluctance to disclose.

Because human trafficking and exploitation are, by nature, covert processes, the identification and rescue of the victim can be difficult. As stated, traffickers often move victims from one area to another to reduce the risk of identification, and one of the main problems with the assessment of such individuals is that practitioners may only have a one-time encounter with the victim [97]. Other provider challenges include language barriers, the hidden nature of the crime, lack of self-identification as a victim, confusing or contradictory laws/regulations, lack of organizational protocols, and stereotypes/misconceptions [98].

Several barriers exist that prevent survivors from self-disclosing their experiences, including [98]:

- Unable to self-identify
- Lack of knowledge of services
- Fear of retaliation
- Fear of law enforcement/arrest/deportation
- Lack of trust
- Shame/stigma
- Learned helplessness/PTSD
- Cultural/language barriers
- Lack of transportation

TRAUMA-INFORMED CARE

All interactions with patients, regardless of whether or not they are potential victims of trafficking, should be centered on the patient's experiences, needs, and preferences. Providing patient-centered care means that care will be respectful of and responsive to individual patient preferences, needs, and values and will reflect the patient's values. This should be considered at all stages of assessment, intervention, and continued care/follow-up.

It is important to use a trauma-informed approach when assessing and caring for potential victims, which requires that practitioners understand the impact of trauma on all areas of an individual's life [99]. Physical, emotional, and psychological safety is at the heart of trauma-informed care. This approach allows for trust-building and continued communication, two factors that are vital to ensuring that patients receive the care and support they require.

Being trauma-informed is a strengths-based approach that is responsive to the impact of trauma on a person's life. It requires recognizing symptoms of trauma and designing all interactions with victims of human trafficking in such a way that minimizes the potential for re-traumatization. This involves creating a safe physical space in which to interact with survivors as well as assessing all levels of service and policy to create as many opportunities as possible for survivors to rebuild a sense of control. Most importantly, it promotes survivor empowerment and self-sufficiency. Survivors should also have access to services that promote autonomy and are comprehensive, victim-centered, and culturally appropriate. Additionally, trafficking survivors share that one of the most important steps to being trauma-informed is to be survivor-informed [100].

POTENTIAL RED FLAGS

Bruises, scars, and other signs of physical abuse may be missed on examination, as victims are often beaten in areas hidden by clothing (e.g., the lower back) so as not to affect the victim's outer appearance. Physical trauma symptoms may be present, commonly on the torso, breast, and/or genital areas [101]. Burns, broken bones, pelvic pain, and/or STIs (particularly in children) may also be red flags [102]. However, more common physical injuries are also typical with other circumstances, making physical exam of limited value. The entire clinical picture should be considered.

It may also be helpful to assess for tattoos and/or other modifications (e.g., branding, piercings). Some perpetrators use tattoos to identify victims or to signify "ownership" [60].

With regard to episodic clinical encounters, recommendations for providing safe assessments in a culturally sensitive manner are lacking. The Department of Health and Human Services Administration for Children and Families maintains a useful website that addresses practical issues of human trafficking for allied professional groups, known as the Look Beneath the Surface Campaign [76]. Included are diagnostic and interviewing tips to help healthcare providers recognize and refer trafficking victims to appropriate services [76]. Emergency and primary care providers should be cognizant of clues that a patient may be the victim of trafficking and prepared to engage in a greater depth of inquiry with special attention to the following indicators [76; 102; 103; 104]:

- Does someone, other than family, who behaves in a controlling manner, accompany the patient? Traffickers attempt to guard and control most every aspect of the victim's life, while maintaining isolation from family, friends, and other common forms of human interaction.
- Are there inconsistencies in answers to basic questions (e.g., name, age, address)?
- Does the patient speak English? If not, has he or she recently been brought to this country, and from where? Many victims of human trafficking have recently been trafficked from other countries. As discussed, common sending countries/regions include Eastern Europe, Asia, Latin America, Africa, India, and Russia.
- If the patient is accompanied by someone other than a family member, who does the talking, and why? Attempt to interview and examine the patient separately and alone, using an interpreter if necessary. Probe in a sensitive manner for detailed information on the situation and relationship.
- Does the patient show signs of psychosocial stress (e.g., appears withdrawn, submissive, fearful, anxious, depressed)? Can the individual account for this?
- Are there visible signs of physical abuse (e.g., bruises, lacerations, scars)? How does the individual explain these?
- Does the patient lack a passport or other immigration and identification documentation (e.g., driver's license, social security number, visa)? If so, what explanation is given? To control victims' movements, traffickers often take away passports and any legal identification documents.
- What is the patient's home and work situation? Basic questions about what they eat, where they live and sleep, who else lives with them, and what work they do can be revealing. For example, "Can you leave your work or job situation if you wish?" or "When you are not working, can you come and go as you please?"
- Is the explanation given for the clinical visit consistent with the patient's presentation and clinical findings?
- Does the victim appear fearful when asked questions about citizenship, country of origin, immigration status, or residence? This may indicate a fear of deportation.
- If the victim is a minor, is s/he in school? Living with parents or relatives? If not, what reasons are given for these circumstances?

If answers to these questions indicate that an individual may be a victim of human trafficking, one should contact the National Human Trafficking Hotline at 1-888-373-7888. Under the child abuse laws, practitioners who are mandated reporters and who are suspicious that a minor is being abused should immediately report the abuse. For more information regarding specific states' reporting requirements, please visit https://www.childwelfare.gov/resources/states-territories-tribes/state-statutes.

SCREENING QUESTIONS

Examples of questions to screen for human trafficking include [105; 106; 107]:

- Can you tell me about your living situation?
- Has anyone ever threatened you with violence if you attempted to leave?
- Does anyone force/require you to have sexual intercourse for your work?
- Has anyone ever threatened your family if you attempted to leave?
- Does anyone make you feel scared at work?
- Are you free to come and go as you wish?
- Does your home have bars on windows, blocked windows/doors, or security cameras?
- How many hours do you work?
- Have you ever worked without receiving payment you thought you would get?
- Do you owe your employer money?
- Do you have to ask permission to eat, sleep, use the bathroom, or go to the doctor?

The Polaris Project has developed a flow chart for the assessment of potential trafficking victims, available at https://www.traffickingresourcecenter.org/sites/default/files/Assessment%20Tool%20-%20Medical%20Professionals.pdf. Again, if a person is thought to be a victim, healthcare providers should follow workplace protocols and/or contact the National Human Trafficking Hotline at 1-888-373-7888 for next steps.

INTERVIEWING TRAFFICKED VICTIMS: BEST PRACTICE GUIDELINES

What should a practitioner consider when interviewing a victim of human trafficking?

Service providers should repeatedly weigh the risks and benefits of various actions when interviewing human trafficking victims [70; 108; 109]. Survivor safety is of utmost importance, and a private conversation should be sought, if at all possible. It may be necessary to be discrete or nonchalant when requesting to speak with the victim alone, as angering the trafficker may result in negative consequences for the victim. If the agency has a policy to always speak to patients alone, this may be easier to explain. Other strategies to separate a possible victim from a companion include stating the need for a private exam or testing (e.g., radiology, urine test). A companion's assistance with paperwork may also be requested in an outside office or lobby. If the potential victim does not want to be alone or is reluctant to go to a private location, it is vital to respect her/his wishes.

In addition, the following interviewing recommendations were published by the World Health Organization to encourage service providers to continually and ethically promote human trafficking victims' safety during every phase of the interviewing process [102; 110]:

- Each victim and trafficking situation should be treated as unique; there are no standard templates of experiences. Listen carefully to the victim's story. Each story told is unique, and each patient will voice distinctive concerns. Believe each story, no matter how incredible it may seem. As rapport and trust build (perhaps very slowly), accounts may become more extensive.
- Always be safe and assume the victim is at risk of physical, psychological, social, and legal harm.
- Evaluate the risks and benefits of interviewing before starting the interviewing process. The interviewing process should not invoke more distress. In other words, the interviewing process should not end up re-traumatizing the victim.
- Provide referrals for services where necessary; however, it is necessary to be realistic and not make promises that cannot be kept. Trust is vital because it has been severed on so many levels for trafficking victims.
- Victims' readiness to change will not be based on what society defines as "ready" or on social expectations. Some victims will eagerly grasp new opportunities, while others may be fearful of potential traffickers' threats and be less receptive to help.
- Determine the need for interpreters and if other service providers should be present during the interviewing phase. Ensure that everyone involved is adequately prepared in their knowledge about human trafficking, how perpetrators control their victims, and how to ask questions in a culturally sensitive manner. Keep in mind that often times, traffickers will offer to help with the interpreting. Using interpreters from the same community of the victim should be avoided to prevent breaches in confidentiality.
- All involved should be prepared with an emergency plan. For example, is there a set plan for a victim who indicates he/she is suicidal or in danger of being hurt?
- Always be sure to obtain informed consent. Remember that the informed consent process is going to be unfamiliar to many victims. In addition, self-determination and autonomy have been compromised by continual threats and being forced to commit dehumanizing acts. Avoid using legal and technical jargon.

Providers should assume that human trafficking victims are describing their reality to the best of their ability, given the trauma they have experienced. Responses and behaviors (e.g., being guarded, defensive, belligerent) may be coping mechanisms [99].

SAFETY MEASURES

While it may be necessary to modify the approach depending on the situation, the Advocates for Human Rights recommends that safety plans for trafficking survivors [111]:

- Are personalized, realistic, involve friends and family that the victim trusts, and cover every aspect of the victim's life
- Focus on improving safety in the victims' environment
- Assess the current risk and identify current and potential safety concerns
- Create strategies for avoiding or reducing the threat of harm
- Outline concrete options for responding when safety is threatened or compromised, including:
  - Determining who victims will call in an emergency and memorizing those phone numbers or preparing a small card listing the numbers
  - Identifying where victims will go if there is an emergency

    - Identifying what victims will do if the trafficker contacts them after they leave the trafficking situation (e.g., retain messages, contact the police or a victim advocate)
    - Assessing how to handle safety issues when victims have family or friends, including those in another country, who are at risk of harm from the trafficker
- Are re-evaluated at various stages of the trafficking situation
- Reflect changing circumstances in the victim's life and changes in support or services (e.g., victims may have felt safe with a particular situation at the time of preparing the safety plan, but they may not feel safe in that same situation in the future)
- Address what victims will do in response to flashbacks or triggers, including those in any new workplace
- Strategize how to address and replace tech-nology, such as cell phones, that the trafficker provided or had access to (e.g., leaving phones in places victims are allowed to be or providing phones just for calling 911)

In addition, non-U.S. citizens should have access to an emergency contact in the United States (potentially a legal services provider) and plans for young children (i.e., a decision-making proxy). Youth victims may require housing assistance [111].

DOCUMENTATION

Ideally, the victim of human trafficking should be offered a formal forensic evaluation; this requires written documentation of informed consent. Injuries should be documented in photographs, diagrams, or sketches. A growing number of hospitals now employ dedicated forensic nurses as part of a multispecialty sexual assault team [112]. Often, however, these trained specialists are not the first professionals to interact with the patient. Consequently, all healthcare professionals, particularly those in an emergency care setting, should have an understanding of the principles that govern proper collection and preservation of evidence during the examination of an assault victim.

The initial clinical assessment includes a careful history and physical examination, followed by selected laboratory testing and radiographic studies as indicated by clinical findings. Examination of the forensic patient is conducted in a thorough head-to-toe or toe-to-head manner, with the intent of documenting every indication of injury related to the incident (no matter how insignificant and involving every part of the body) using a body-map or wound chart. The entire body surface should be palpated to identify areas of bruising that may not yet be visible. Documentation and collection of evidence typically occurs at the same time as the physical exam—as evidence is detected it should be collected.

Forensic documentation includes a written component, a diagrammatic component, and a photographic component. Each should accurately inform the other. The written component must be detailed, accurate, and objective; the diagrammatic component must be thorough and legible; and the photographic component must include a measurement scale, be representative of the evidence, and remain objective.

RESPONSE AND FOLLOW-UP

HEALTHCARE PROVIDERS' ROLE

Care and services provided to victims can be organized into three distinct categories: immediate and concrete services at the time of rescue; services related to recovery; and long-term services pertaining to reintegration [113]. When trafficking victims are rescued, a great deal of counseling services and practical, day-to-day assistance will be required. Housing, transportation, food, clothing, medical care, dental care, financial assistance, educational training, reunification (for those who wish to return to their homeland), and legal aid are some of the concrete services needed [24]. Practitioners should connect, coordinate, and case manage these services as much as possible. During this stage, it is also important to understand victims' needs, their strengths, and their risks and vulnerabilities [82].

Safety planning is also crucial in the immediate rescue stage. Traffickers may be continuing to try to locate some victims; placing victims in safe houses may be necessary [86]. The National Human Trafficking Hotline encourages that safety planning be based on the unique needs and circumstances of the individual. One should also take steps to ensure that one's own safety is also protected.

During the recovery and reintegration stages, as discussed, human trafficking victims experience an array of mental health and psychological issues. Mental health counseling is vital, but it is important to remember that the concept of counseling or talk therapy may be foreign to victims from non-Western cultures [70]. The expression of emotions may be in opposition to cultural values of emotional restraint, which can be intensified by feelings of shame and guilt resulting from experiences with sexual and physical assault. Beyond the paramount importance of the practitioner gaining the patient's trust, practitioners may educate patients about the counseling process and explore their patients' expectations about counseling, healing, and recovery [114]. As noted, victims' symptoms may not only be a manifestation of the trauma but also coping mechanisms to cope with self-blame, shame, and trauma [60].

Given differing cultural beliefs about healing, it is crucial that practitioners be open to alternative treatment and explore with patients the use of traditional healing methods [70]. There are many indigenous healing interventions victims may be using, including cultural rituals, faith healing, therapeutic touch, herbal remedies, and spiritual practices [115].

These interventions are multi-layered, taking into account the physical, psychological, communal, and spiritual [115]. These healing methods are historically rooted in specific cultures, and therefore, practitioners should become familiar with traditional healing methods and how they can be integrated with Western counseling techniques [114]. For example, given many cultural groups' beliefs that unmarried girls are defiled if raped, a cultural cleansing ritual may be needed as a first step to help a community accept a returning victim who was sexually assaulted during her trafficking experience [36]. After this ritual is performed, it is possible that both the patient and her family may be more open to counseling and other services.

Other trauma interventions that might be beneficial include cognitive-behavioral therapies, eye movement and desensitization reprocessing therapies, mindfulness techniques, and expressive therapies [60; 86].

Physicians, social workers, nurses, therapists, and counselors must be familiar with legal, case management, educational, job and life skills training, and housing services in the community. Human trafficking victims are not only unfamiliar with navigating the social service system, but many are also not proficient in English. Therefore, practitioners will serve as coordinators and advocates, linking necessary services. In one study, the majority of agencies had to rely on collaboration in order to refer clients [116]. Social workers and practitioners relied on word-of-mouth and community meetings to learn about services in order to better meet the needs of human trafficking victims. Furthermore, because many community organizations and agencies are not familiar with human trafficking, practitioners must take a primary role in educating colleagues about the complex dynamics of human trafficking.

It is important to remember that the evidence supporting interventions and therapies for victims of human trafficking is in its infancy [113]. Most efficacy studies of therapies and interventions do not involve experimental designs, which makes it difficult to draw definitive conclusions regarding efficacy. Future work is needed to develop and evaluate interventions that address the multilayered and complex needs of human trafficking survivors.

REFERRAL

In the initial period, what should referral of trafficking victims focus on?

The needs of human trafficking survivors are diverse, and healthcare professionals should be prepared to refer these individuals to a wide variety of services. In the initial period, acute injuries, mental health crises, and stabilization (e.g., housing, safety) are the greatest concerns. However, many victims experience chronic health and mental health issues related to their traumatization and will also require referral to services that will allow healing throughout their lifetimes.

As such, organizations and healthcare providers should work to build a trusted local network of resources, including substance abuse treatment centers, educational and career advancement services, financial support, PTSD/complex trauma assessment and treatment, and potentially law enforcement representatives with experience providing services to victims of human trafficking. In the state of Texas, statewide and local organizations and government offices are available to assist in building this network. A listing of these resources is available at the end of this course.

The National Human Trafficking Hotline (administered by Polaris) also maintains a National Referral Directory that is searchable by gender, nationality, age, type of trafficking, type of service(s), opportunities/training, and geographic location. The directory is available at https://humantraffickinghotline.org/en/find-local-services.

REPORTING

In addition to addressing crises and stabilization upon identification of a potential trafficking victim, healthcare providers should contact the National Human Trafficking Hotline. This hotline also provides warm transfers of mandatory reporters' intakes to the Texas Department of Family and Protective Services (DFPS), helps build intelligence on human trafficking in Texas, and continuously improves its referral directory of Texas resources for victims seeking assistance for themselves. There are more than 90 Texas service providers listed on the National Referral Directory, with more than 60 of those being listed publicly.

According to Texas Family Code 261.101, any person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect (including human trafficking victimization) by any person is required to immediately make a report to law enforcement or DFPS [117]. Professionals who are licensed or certified by the state or who are employees of a facility licensed, certified, or operated by the state and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children are required to make reports within 48 hours; this includes physicians, nurses, social workers, counselors, and pharmacists. Reporting cannot be delegated.

ROLES AND LIMITATIONS OF LAW ENFORCEMENT INVOLVEMENT

Victims of human trafficking should be empowered with choice whenever possible, including the ability to determine whether to participate in the criminal justice process [100]. Cases involving abuse or neglect at the hands of a traditional caregiver may be investigated by the DFPS, but all other cases must be handled by a law enforcement agency [118]. For victims who choose to participate in the criminal justice process, safety and protection considerations apply.

There are limitations to law enforcement involvement, particularly with victims who may be reluctant to trust these figures. It is important that the law enforcement contact be trained and experienced in the intricacies of human trafficking and complex trauma. While building a criminal case and prosecuting perpetrators is important, measures should be taken to avoid re-traumatizing the victim.

ORGANIZATIONAL PROTOCOLS

Whenever possible, facilities should create trauma-informed organizational protocols to ensure that human trafficking survivors receive the best possible care. These protocols should include guidelines for appropriate assessment, documentation, reporting, intervention, and referral and may be incorporated into existing protocols for interacting with potential victims of child abuse, violence, and/or sexual assault.

CONCLUSION

Human trafficking is a severe human rights violation. Because the roots of human trafficking are multifaceted, no one solution exists to eliminate this problem. Unfortunately, as the problem grows, practitioners will be confronted with the issue in their patient populations. Practitioners should be committed to the collaboration amongst disciplines to address poverty, racism, discrimination, and oppression in order to reduce the vulnerable positions of human trafficking victims and their families. Because of the social justice component in the codes of ethics of professionals such as physicians, nurses, social workers, psychologists, and counselors, all practitioners can play a key role in the individual, community, and systemic levels to help address this gross abuse of power. One way to begin is to educate oneself and one's respective disciplines about the global nature of human trafficking and the complex dynamics of the problem.

RESOURCES

NATIONAL

National Human Trafficking Hotline
https://humantraffickinghotline.org
1-888-373-7888
TTY: 711
Text: 233733

U.S. Department of Homeland Security
https://www.dhs.gov/blue-campaign

U.S. Department of State
Office to Monitor and Combat Trafficking in Persons
https://www.state.gov/bureaus-offices/under-secretary-for-civilian-security-democracy-and-human-rights/office-to-monitor-and-combat-trafficking-in-persons

Girls Education and Mentoring Services (GEMS)
https://www.gems-girls.org

Love146
https://love146.org

National Center for Missing and Exploited Children
https://www.missingkids.org

Administration of Children and Families
Office on Trafficking in Persons
https://www.acf.hhs.gov/otip

Polaris Project
https://polarisproject.org

Shared Hope International
https://sharedhope.org

Truckers Against Trafficking
https://truckersagainsttrafficking.org

STATE

Children at Risk
https://childrenatrisk.org/human-trafficking

Children Advocacy Centers of Texas
https://www.cactx.org

Office of the Texas Governor
Child Sex Trafficking Team
https://gov.texas.gov/organization/cjd/childsextrafficking

Attorney General of Texas
https://www.texasattorneygeneral.gov/initiatives/human-trafficking

Texas Health and Human Services
https://hhs.texas.gov/services/safety/texas-human-trafficking-resource-center

Texas Youth Connection
https://www.dfps.state.tx.us/txyouth

LOCAL

To locate your county by DFPS region, please visit https://www.dfps.state.tx.us/contact_us/counties.asp.
Organizations marked with an asterisk are faith-based.

DFPS Region 1 (Northwest)

Family Support Services of Amarillo
https://fss-ama.org

No Boundaries International*
https://www.nbint.org

Open Door Survivor Housing Lubbock*
https://opendoorlbk.org

Voice of Hope Lubbock Texas
https://www.voiceofhopelubbock.org/sex-trafficking

DFPS Region 2 (Northwest)

Taylor County Victim's Assistance Division
https://www.taylorcounty.texas.gov/130/Victims-Assistance-Division

Wichita County Victim Assistance
https://wichitacountytx.com/victims-services

DFPS Region 3 (Dallas Fort Worth)

Mosaic
https://mosaicservices.org

Jonathan's Place
https://www.jpkids.org

New Friends New Life, Dallas
https://www.newfriendsnewlife.org

Promise House Dallas*
https://promisehouse.org

Refuge for Women, North Texas*
https://refugeforwomen.org/north-texas

Traffick911
https://www.traffick911.com

Unbound
https://www.unboundnow.org

DFPS Region 4 (East Central)

Texas Legal Services Center
https://www.tlsc.org

DFPS Region 5 (East Central)

Crisis Center of Southeast Texas
https://www.crisiscenterofsoutheasttx.org

Jefferson County Victims' Assistance Center
https://co.jefferson.tx.us/da/VictimsAssist.htm

Children at Risk, Houston
https://childrenatrisk.org/human-trafficking

For the Silent, Tyler, TX
https://www.forthesilent.org

Houston Area Women's Center
https://hawc.org

YMCA of Greater Houston
https://ymcahouston.org

DFPS Region 6 (Houston)

Free the Captives Houston*
http://www.freethecaptiveshouston.com

Houston Area Women's Center
https://hawc.org

The Key2Free
https://www.thekey2free.org

United Against Human Trafficking
https://uaht.org

DFPS Region 7 (East Central)

American Gateways, Austin
https://americangateways.org

Asian Family Support Services of Austin
https://www.afssaustin.org

Central Texas Youth Services Bureau, Belton/Temple
https://www.centraltexasyouthservices.com

The Refuge for DMST, Austin*
https://therefugedmst.org

Unbound
https://www.unboundnow.org

DFPS Region 8 (South)

Alamo Area Coalition Against Trafficking
https://www.facebook.com/alamoacat

Freedom Youth Project Foundation
https://www.freedomyouthproject.org

The Rape Crisis Center, San Antonio
https://rapecrisis.com

DFPS Region 9 (Northwest)

Ector County District Attorney Office
http://www.co.ector.tx.us/page/ector.District.Attorney

Midland County District Attorney Office
https://www.co.midland.tx.us/173/District-Attorney

DFPS Region 10 (Northwest)

Las Americas Immigrant Advocacy Center
https://las-americas.org

El Paso Center for Children
https://epccinc.org

Paso Del Norte Center of Hope
https://www.pdncoh.org

Salvation Army of El Paso*
https://southernusa.salvationarmy.org/elpaso

DFPS Region 11 (South)

Catholic Charities of Corpus Christi Texas*
https://www.catholiccharities-cc.org

Coastal Bend Coalition Against Modern Day Slavery
https://cbcamds.wordpress.com

Mujeres Unidas/Women Together Foundation, Inc.
https://mujeresunidas.org

Customer Information/Evaluation insert located between pages 16–17.

COURSE #97770 — 5 CONTACT HOURS **Release Date: 05/01/23** **Expiration Date: 04/30/26**

Counseling Patients at the End of Life

This course meets the Texas requirement for 2 hours of Geriatrics education.

Audience

This course is designed for all members of the interprofessional team responsible for supporting patients at the end of life.

Course Objective

The purpose of this course is to provide physicians, nurses, physician assistants, and allied health professionals with the knowledge and strategies necessary to best assist patients to seek and receive optimal end-of-life care.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define palliative and end-of-life care.
2. Outline the role of health and mental health professionals in end-of-life counseling.
3. Identify psychological concerns present at the end of life.
4. Discuss key components of end-of-life conversations.
5. Analyze mental health interventions that can be incorporated into end-of-life care and bereavement.
6. Describe practical, ethical, and legal issues that can arise in the provision of end-of-life care.
7. Examine the impact of culture and culturally competent care on end-of-life decisions and support.

Faculty

Lisa Hutchison, LMHC, has more than 20 years of experience providing individual and group counseling with adults. She specifically focuses on teaching assertiveness, stress management, and boundary setting for empathic helpers. Ms. Hutchison graduated from the University of Massachusetts, Boston, with a Master's degree in education for mental health counseling.

Faculty Disclosure

Contributing faculty, Lisa Hutchison, LMHC, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Senior Director of Development and Academic Affairs

Sarah Campbell

Division Planner/Director Disclosure

The division planner and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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EVIDENCE-BASED PRACTICE RECOMMENDATION

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the study questions and course material for better application to your daily practice.

INTRODUCTION

End-of-life decisions can be complex and challenging. Health and mental health professionals can help with their expertise, whether it is for the person facing death, their family, surrogate decision makers, or caregiver. It is vital for health and mental health professionals to learn when and how to include end-of-life discussions into their sessions, assist with decision making and planning, and learn the differences between palliative and end-of-life care.

DEFINING END-OF-LIFE CARE

What is the goal of palliative care?

The terms palliative care and end-of-life care often are used interchangeably, but there are some differences. The goal of palliative care is to improve the quality of life of patients and their families when faced with life-threatening illness. This is achieved through the prevention and relief of suffering and treatment of pain and other physical, psychosocial, and spiritual problems [1]. Palliative care includes measures used to achieve comfort for the patient. Palliative care can be provided at any stage of a serious illness, including as early as the time of diagnosis. Unlike patients receiving end-of-life care, those receiving palliative care may still be pursuing curative treatment [2].

End-of-life care (which may include palliative care) is generally defined as care that is provided to seriously ill patients who have a prognosis of six months or less. It is care intended for the last few weeks or months of a patient's life. End-of-life care can be provided in a variety of settings, including the patient's home, nursing homes or assisted living facilities, or inpatient hospice facilities [2]. End-of-life care is a multidisciplinary team approach toward "whole person care." It is intended for people with advanced, progressive, incurable, or life-limiting illness to enable them to live as well as possible before they die [3]. This course will focus on end-of-life care.

THE ROLE OF HEALTH AND MENTAL HEALTH PROFESSIONALS IN END-OF-LIFE COUNSELING

Which professionals can provide end-of-life counseling?

The transition of care from eliminating or mitigating illness to preparing for death can be difficult for patients, families, and caregivers, and it can be equally difficult for healthcare professionals, who are expected to meet the physical and emotional needs of dying patients and their families [4]. By understanding the experiences of the dying patient, health and mental health professionals can best support the unique needs of each patient and the patient's loved ones as well as self and other members of the patient's healthcare team [4; 5; 6; 7]. Mental health professionals are uniquely positioned to address the cognitive, mental, and emotional needs that arise during this period of life-limiting illness [8; 9]. They work to normalize emotions during a difficult time; provide spiritual support; educate about normal physical, emotional, and social changes; and assist in managing practical problems. They also may develop relationships with survivors to provide a continuity of care following the patient's death. Health and mental health professionals work in a variety of settings that address end-of-life care, including health agencies, hospitals, hospice and home care settings, nursing homes, and courts [10].

Both end-of-life and palliative counseling are services provided by clinicians who work with the terminally ill. End-of-life counseling helps patients struggling with death or families struggling with the death of a loved one and may be provided by counselors, therapists, social workers, psychologists, critical care nurses, physicians, hospice workers, and others trained in working with emotions related to death, dying, grief, and bereavement [8].

Health and mental health providers provide services to diverse individuals in a variety of settings, including end-of-life settings, as part of an interprofessional team. In the end-of-life setting, clinicians help dying patients prepare for death with education and supportive therapeutic interventions that address the patient's physical, emotional, social, spiritual, and practical needs [10]. They also help patients and their families navigate the many challenges associated with dying, including end-of-life planning; managing stresses associated with life-limiting illness; assessing patients to develop interventions and treatment planning; advocating for patients' treatment plans; overcoming crisis situations; and connecting them with other support services [11; 12]. Life-limiting illness is mentally taxing and can exacerbate or incite symptoms of anxiety, depression, and trauma and make manifest complex presentations of cognitive decline. Providers can help differentiate between trauma symptoms, mental illness, or medical decline. Reducing mental health symptoms can help patients engage more meaningfully, including in the participation of end-of-life decisions [9]. A cohesive, standardized approach to end-of-life care addresses issues related to the patient, family, caregivers, and the team of healthcare professionals involved in providing care [12].

PSYCHOLOGICAL CONCERNS FOR PATIENTS AT THE END OF LIFE

Psychological suffering is a universal experience for patients at the end of life. It exists on a continuum and has many sources, including grief over anticipated loss or worry about unresolved issues. It is important to assess and differentiate the major types of distress in the dying patient and among their families to effectively treat these sources of suffering.

LIFE-CYCLE ISSUES/RELATIONSHIPS

Psychological responses to the news of a life-limiting illness will vary according to the patient's developmental stage. The young adult, about to become independent, might struggle with being thrust back into dependence upon parents or other adult figures. Parents of young children with life-limiting illness often are consumed with what and how much to tell their ill child, the impact of the child's illness on other siblings, and how to cope with the loss of the child's future. Worries about a spouse or partner are a common concern for older adults. They may feel cheated out of the expected rewards of a life of hard work. Worries about family members are a major issue for most patients at the end of life [13]. One study found that 92% to 97% of patients rated as extremely or very important "feeling appreciated by my family," "saying goodbye to people closest to me," "expressing my feelings to family," and "knowing that my family will be all right without me" [14]. Caregivers of patients with terminal illness also experience significant strains (e.g., adverse impact on work and finances) [15]. Awareness of these life-cycle and relationship issues can help the clinician listen for and inquire about concerns and emotions, normalize patient responses, and explore areas of distress [13].

MEANING AND IDENTITY

Illness comes with practical and emotional challenges that are unique to each patient. The clinician who understands what the illness means to the patient can identify specific concerns, address fears, provide reassurance, and help the patient make plans. Providing patients with the opportunity to share what their illness means can be therapeutic in and of itself [13]. Some patients state that finding meaning in illness is derived from the belief that their life has a purpose that extends beyond self. Others find that meaning enhances their ability to cope with their illness. Still others experience a loss of meaning when faced with life-limiting illness. The patient's ability to find and maintain a sense that life has purpose and meaning is associated with the ability to tolerate physical symptoms of the illness and protect against depression and a desire for hastened death [13]. Meaning and hope are closely allied in patients at the end of life, and hopes for the future reflect the patient's priorities.

Maintaining a sense of self is a high priority among patients with life-limiting illness, yet serious illness has a profound impact on patient self-identity. The physical and psychological losses (e.g., loss of feeling whole, loss of independence, loss of control) present major challenges to the patient's emotional health. Control and independence often are combined in the literature to mean the patient's dignity, or the "quality or state of being worthy, honored, or esteemed" [13]. Preservation of this dignity should be a primary concern of end-of-life care practitioners.

COPING AND STRESS

What is a possible negative effect of denial in patients at the end of life?

Confronting a life-limiting illness causes patients to make psychological adjustments to preserve equilibrium. Coping responses can include seeking information about the illness, staying busy to avoid thinking about the illness, resigning one's self to the illness, examining alternatives, and talking about feelings. Effective coping occurs when the patient is able to use active problem-solving strategies. Yet, as illnesses progress, patients' ability to perform cognitive tasks can decline. Some patients cope by defending against or denying the reality of their illness to fend off acute emotional distress. The dynamic tension between coping and defending/denying causes most patients to use a combination of these responses [13]. While denial is a powerful mechanism that helps preserve psychological equilibrium, it can have many negative effects, including refusal to accept death; lost trust in the healthcare team; focus on unrealistic treatment goals; and failure to make legal, financial, and healthcare arrangements [13]. Life-limiting illness represents a major adaptational challenge to patients' learned coping mechanisms. Psychosocial stressors enhance the likelihood that a patient will become depressed. Practical stressors (e.g., relationships, work, finances, legal matters) also can impact patients' ability to cope with their illness. Economic circumstances have been found to be a major stressor for patients and their families, often resulting in a decline in family economic well-being [13]. In one study, 20% of family members of seriously ill adult patients had to make a major life change (including quitting work) to care for their loved one; up to 31% of families lost all or most of their savings while caring for their ill loved one [14].

Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) may first emerge, re-emerge, or worsen as individuals approach the end of life and may complicate the dying process. Unfortunately, lack of awareness of the occurrence and/or manifestation of PTSD at the end of life can result in it being unaddressed in these patients. Even if PTSD is properly diagnosed, traditional evidence-based, trauma-focused treatments may not be feasible or advisable for patients at the end of life, as they often lack the physical and mental stamina to participate in traditional psychotherapy [16]. Many therapies for PTSD require a longer window of treatment than a typical hospice period. Providers can tailor treatment for short-term interventions or use approaches such as the Stepwise Psychosocial Palliative Care (SPPC) model. The SPPC model is a multidimensional approach, integrating environmental, problem-solving, and other psychosocial interventions with patient advocacy in a patient-centered, time-sensitive manner. It incorporates techniques drawn from evidence-based approaches to PTSD, deploying them in a stage-wise manner appropriate for patients at the end of life [17]. Debriefing interventions have been widely used to treat PTSD and the psychological sequelae of traumatic events, and these approaches can be appropriate in the end of life. Further, antidepressant, antianxiety, and antipsychotic agents may be used to manage intense symptoms. Support groups and psychoeducational approaches are also common approaches, but evidence of their effectiveness in this setting is lacking [13].

ANTICIPATORY GRIEF

Anticipatory grief is the experience of grieving the loss of a patient or loved one in advance of their death [18]. It is a response to impending loss of life, identity, function, hopes, and future plans and is associated with anxiety, depression, hopelessness, and strained communication [19]. Other intense emotions, such as fear and panic, can appear as a result of unexplained symptoms and uncertainties regarding treatment [20]. One study evaluated anticipatory grief in 57 family members of patients with terminal illness receiving palliative care services [18]. Elevated anticipatory grief was found in families characterized by relational dependency, lower education, and poor grief-specific support. These families also experienced discomfort with closeness and intimacy, neuroticism, spiritual crisis, and an inability to make sense of the loss [18]. Patients, families, caregivers, and clinicians all can experience anticipatory grief. Several factors (e.g., spiritual beliefs, quality of relationships, attitudes of close others or colleagues/peers) can influence the anticipatory grief toward either positive or negative outcomes [21].

As a core component of psychological flexibility, acceptance is beneficial in situations in which individuals have little or no control over circumstances, such as when faced with a life-limiting illness. Acceptance becomes an active process wherein the patient acknowledges and opens up to their situation in order to make the most of their remaining time. Although acceptance shares a strong relationship with anticipatory grief, depression, and anxiety, it is independent of anxious and depressive symptomatology and more likely to predict the level of anticipatory grief than anxiety or depression. A higher degree of acceptance is associated with lower anticipatory grief in patients in palliative care [19]. When anticipatory grief is an expression of past or current trauma, it may develop into complicated grief if left untreated. A thorough assessment is warranted to determine if the grief is current or connected to unresolved trauma. Consider treating the initial trauma before the anticipatory grief. At the end of life, if time does not allow for intensive treatment, look to reduce individual trauma symptoms or grief.

ANXIETY AND FEAR

Death is an ever-present reality despite increasingly technologically advanced health systems, longer survivals, and novel curative treatments for life-threatening conditions [22]. Fear of the unknown has been described as the propensity to experience fear caused by the perceived absence of information at any level of consciousness or point of processing [23]. Fear of death and dying is common. In one study, a majority (70%) of participants reported some, a little, or no fear of death and dying; 30% reported more severe fears [24]. A common fear in Western society is that the process of dying will be painful and prolonged and will reduce the quality of life. Other fears associated with death include [25]:

- Fear of separation from loved ones, home, and job
- Fear of becoming a burden to others
- Fear of losing control
- Fear for dependents
- Fear of pain or other worsening symptoms
- Fear of being unable to complete life tasks or responsibilities
- Fear for the fears of others (reflected fear)
- Fear of being dead

It is important that clinicians allow patients a full expression of these fears, without judgment. Patients with anxiety often cannot take in information and may ask the same questions over and over again. They may seek detailed information or not ask reasonable questions. They may be suspicious of the physician's recommendations or not ask questions because of regression or high levels of fear. They may over-react to symptoms or treatments or behave inexpressively and stoically. Their behavior may seem inconsistent and impulsive [13]. An ongoing assessment of anxiety symptoms and anxiety's various presentations is critical to maintaining the patient's mental health. Equally important is that the clinician recognize that anxiety in end-of-life care also may be the result of a pre-existing anxiety disorder or other undertreated symptoms, especially pain. A multidrug treatment regimen in the palliative care setting also can contribute to anxiety [13].

Thanatophobia

Thanatophobia is an extreme fear of death or of the dying process [26]. Fear of death as a disease entity behaves much like initial anxiety due to trauma that leads to PTSD [27]. Evidence suggests that thanatophobia is highest in patients who do not have high self-esteem, religious beliefs, good health, a sense of fulfillment in life, intimacy, or "a fighting spirit" [27]. While anxiety, depressive symptoms, and beliefs about what will happen after death can contribute to a patient's fear, death anxiety does not always follow after a diagnosis of life-limiting illness [27]. It appears to be a basic fear at the core of a range of mental disorders, including hypochondriasis, panic disorder, and anxiety and depressive disorders [28]. Antecedents of death anxiety include stressful environments and the experience of unpredictable circumstances, diagnosis of a life-threatening illness or the experience of a life-threatening event, and experiences with death and dying. Consequences of death anxiety include both adaptive and maladaptive presentations. When encountering death anxiety in a patient, assess for PTSD and the various anxiety disorders to determine whether it is anxiety-based or associated with an underlying trauma [22].

Death anxiety is a central feature of health anxiety and may play a significant role in other anxiety disorders [29]. Exposure to death-related themes has been found useful for the treatment of death anxiety [29]. A 2015 study that assessed death anxiety among patients with life-limiting cancer found that life stage, particularly having dependent children, and individual factors, such as lower self-esteem, increased patients' vulnerability to death anxiety [30]. Depressive symptoms also have been reported in health professionals who work with dying patients [31]. A 2011 study sought to assess the impact of death and dying on the personal lives of clinicians involved in end-of-life care [32]. Early life experiences and clinical exposure to death and dying helped the clinicians to live in the present, cultivate spirituality, and reflect on their own mortality and the continuity of life. Despite reporting accounts of death's ugliness, participants consistently described the end of life as a meaningful life stage [32]. Yet, not all clinicians find that working with patients at the end of life decreases their death-related anxiety, and many will require support and guidance. Burnout and death anxiety can be emotionally devastating, resulting in impaired performance that makes the goal of quality patient care almost impossible to accomplish [33]. All providers of end-of-life care should be reminded that they are not alone and that they can rely on other members of the healthcare team [34].

Education about death also may be helpful. In a 2015 study of 86 human services professionals, participation in a course on death, dying, and bereavement was shown to significantly reduce clinicians' fear of death and death anxiety [35]. In a study that included 42 nurses enrolled in death education programs, some affirmative impacts on the death distress of participants was observed [31]. Younger nurses consistently reported a stronger fear of death and more negative attitudes towards end-of-life patient care, indicating that workplace education might be beneficial [36]. One study investigated whether a brief induction of gratitude could reduce death anxiety [37]. Participants (mean age: 62.7 years) were randomly assigned into one of three conditions (gratitude, hassle, and neutral) and asked to write about a variety of life events before responding to measures of death anxiety. Participants in the gratitude condition reported lower death anxiety than those in the hassle and neutral conditions; no difference was observed between hassle and neutral conditions [37]. Even a temporary relief of death anxiety may help facilitate the making of important end-of-life decisions [37].

PAIN

Pain management is an integral part of palliative care. Pain management in end-of-life care presents unique opportunities in the patient-physician relationship [38]. In some instances, pain can be reduced when the patient has a sense of control and knows what to expect. Patients report feeling empowered by participating in treatment decisions with their physicians [39]. Pain management in children presents special challenges. A multidisciplinary team with an open attitude to differences, listening skills, availability, flexibility, creativity, resourcefulness, and empathy can help the child and his or her family live with the least pain possible [40]. For both adult and pediatric patients at the end life, planning for what could happen is often key. Honest, dynamic discussions about treatment goals and possible options and their respective side effects allows patients and their families to make choices that best fit their wishes [40]. Treating pain at the end of life means caring for all possible manifestations, including physical symptoms as well as psychological symptoms and reduced well-being. This can be achieved by integrating pharmacotherapy with psycho-socio-spiritual interventions [41].

DEPRESSION

Evidence of hopelessness, helplessness, worthlessness, guilt, and suicidal ideation are better indicators of depression in the context of life-limiting illness than neurovegetative symptoms [42]. Yet, diagnosing and treating depression in patients with life-limiting illness remains challenging for several reasons. Typical symptoms of depression (e.g., impaired concentration, anergia, sleep disturbances) also are common symptoms of advanced mental illness, and side effects from medications commonly used at the end of life can mimic depressive symp-

PHYSICAL DEPRESSIVE SYMPTOMS VERSUS REPLACEMENT PSYCHOLOGICAL SYMPTOMS

Physical Symptoms	Replacement Psychological Symptoms
Change in appetite	Tearfulness, depressed appearance
Sleep disturbance	Social withdrawal, decreased talkativeness
Fatigue	Brooding, self-pity, pessimism
Diminished ability to think or concentrate	Lack of reactivity, blunting

Source: [43] *Table 1*

toms. Delirium occurs in up to 90% of patients at the end of life. A mistaken diagnosis of depression in a patient with hypoactive delirium can lead to a prescription for an antidepressant or psychostimulant, which can exacerbate the delirium. To further complicate assessment, patients frequently do not report or may disguise symptoms of depression at the end of life [43]. It can also be difficult to determine if pharmacotherapy or reflective listening would be the appropriate intervention for the specific patient.

An assessment of available screening tools and rating scales for depressive symptoms in palliative care found that the tool with the highest sensitivity, specificity, and positive predictive value was the question: "Are you feeling down, depressed, or hopeless most of the time over the last two weeks?" [43]. One structured approach was found to help clinicians differentiate major depressive disorder from common physical symptoms of the patient's illness. With this approach, physical criteria for a diagnosis of major depressive disorder are replaced by psychological symptoms (***Table 1***) [43].

Some patients fear that being diagnosed with depression will cause their medical providers to stigmatize them or treat their physical symptoms less aggressively. It may then be necessary to address these issues before the patient will be willing to accept treatment for depression [42]. Left untreated, depression in seriously ill patients can be associated with increased physical symptoms, suicidal thoughts, worsened quality of life, and emotional distress. It also can impair the patient's interaction with family and erode patient autonomy [43]. Although patients with terminal illness often have suicidal thoughts, they are usually fleeting. Sustained suicidal ideation should prompt a comprehensive evaluation [42].

SUICIDALITY

Suicide is a response to two stimuli (i.e., pain and despair) that often overlap. The pain can be physical or psychological, but in either aspect, it consumes the person to the point of seeking release. Despair is the result of believing that there is no longer any hope of having a good life [44]. Uncertainty about how death will unfold and whether they will be able to cope can be intensely stressful for patients. For some, suicide may seem preferable to a protracted period of anxiety, uncertainty about the process of dying, and fear of substantial physical suffering [29]. Diagnosis of severe physical illness (e.g., chronic obstructive pulmonary disease, low-survival cancer, degenerative neurological conditions) is associated with higher suicide risk [162].

A Wish to Die

Despite research efforts to deepen understanding of why some patients with terminal illness express a wish to die, there is consensus that there is more to learn about the factors that influence such a wish [45]. A case study review of patients with terminal cancer diagnoses in palliative care sought to understand possible motivations and explanations of patients who express or experience a wish to die [45]. Intentions, motivations, and social interactions were key to understanding and analyzing a patient's wish-to-die statements. The study focused on motivations, which address the question (from the patient's perspective) of why a wish to die is present. Motivations appear to consist of three layers: reasons (the causal factors), meanings (explanatory factors), and functions (effects of the wish) [45]. Patients' motivations were not able to be explained by a single reason, and, for most, their wish to die had broader significance that reflected their personal values and moral understandings—that is, the "meaning" of their wish to die [45]. Patients reported nine types of meanings, with some appearing more frequently than others. The meanings were shaped by patients' personal experiences, cultural background, and relationships. Patients expressed that a wish to die can be a wish to [45]:

- Allow a life-ending process to take its course
- Let death put an end to severe suffering
- End a situation that is seen as an unreasonable demand
- Spare others from the burden of oneself
- Preserve self-determination in the last moments of life
- End a life that is now without value
- Move on to another reality
- Be an example to others
- Not have to wait until death arrives

Health and mental health professionals cannot properly address a patient's wish to die if the meanings of the wish remain unexplored. Meanings are loaded with moral beliefs that need to be understood and respected in communication, disease management, and care of patients and their families [45].

END-OF-LIFE CONVERSATIONS

Helping a patient appoint a surrogate decision maker is part of which step in an end-of-life conversation?

Dr. Elisabeth Kübler-Ross is credited as one of the first clinicians to formalize recommendations for working with patients with life-limiting illness. Her book, *On Death and Dying*, identified a gap in our understanding of how both patients and clinicians cope with death [46]. She wrote that it could be helpful if people could talk about death and dying as an intrinsic part of life [47]. In writing specifically about psychotherapy with the terminally ill, Dr. Kübler-Ross stated: "It is evident that the terminally ill patient has very special needs which can be fulfilled if we take time to sit and listen and find out what they are" [47].

Patients who receive the news that they do not have long to live will experience strong emotions accompanied by questions, which can be viewed as opportunities for clinicians to provide answers and open a broader discussion about the end of life. Such questions (and answers) may include [48]:

- *How long have I got?*

  Giving patients a sense of how much time is left allows them to focus on what is important to them. Answers to this question should be clear and as accurate as possible, while acknowledging that exact timeframes are impossible to know.

- *Will palliative care help?*

  When palliative care is appropriate, it supports patients and their families/caregivers by helping them to manage their physical, mental/emotional, spiritual, and practical needs. For patients at the end of life, palliative care is almost always appropriate.

- *What is a "good death?"*

  The answer to this question varies depending on each patient's attitudes, cultural background, spiritual beliefs, and medical treatments. Patients' wishes regarding where they prefer to die (e.g., at home, in hospital) also should be discussed.

- *How will I know that the end is near?*

  The answer depends on the patient and the patient's illness, but events that commonly occur during the dying process include reduced appetite, gradual withdrawal from the outside world, and sleeping more.

Data derived from a national survey of physicians, nurses, social workers, chaplains, hospice volunteers, seriously ill patients, and recently bereaved family members indicate an overwhelming preference for an opportunity to discuss and prepare for the end of life [39]. And while a majority (92%) of Americans say it is important to discuss their wishes for end-of-life care, only 32% have had such a conversation [49]. A majority of patients also prefer that a healthcare provider initiate end-of-life discussions [50]. It is important to note that these discussions do not have to wait for the end of the patient's life. The American Psychological Association has identified four time periods when health and mental health professionals can contribute to end-of-life care [51]:

- Before illness strikes
- After illness is diagnosed and treatments begin
- During advanced illness and the dying process
- After the death of the patient, with bereaved survivors

The end-of-life conversation can be divided into four simple steps [50]:

- Initiate the discussion:
  - Establish a supportive relationship with the patient and the patient's family.
  - Help the patient to appoint a surrogate decision maker.
  - Elicit general thoughts about end-of-life preferences through the use of probing questions.
- Clarify the prognosis:
  - Be direct yet caring.
  - Be truthful but sustain spirit.
  - Use simple, everyday language.
- Identify end-of-life goals:
  - Facilitate open discussion about desired medical care and remaining life goals.
  - Recognize that, as death nears, most patients share similar goals (e.g., maximizing time with family and friends, avoiding hospitalization and unnecessary procedures, maintaining functionality, minimizing pain).
- Develop a treatment plan:
  - Provide guidance in understanding medical options.
  - Make recommendations regarding appropriate treatment.
  - Clarify resuscitation orders.
  - Initiate timely palliative care, when appropriate.

Optimal end-of-life care begins with an honest discussion between clinicians and patients about disease progression and prognosis [52]. Patients and families are sensitive to verbal and nonverbal cues during these discussions. It is therefore incumbent on the healthcare team to train themselves in active listening skills, correct body language, and appropriate empathic responses in order to convey information in a clear, concise, and empathic manner [3]. Physicians also must balance their desire to honor patient wishes and autonomy against the concern of inflicting psychological harm. A 2008 study sought to determine whether end-of-life discussions were associated with fewer aggressive interventions and earlier hospice referrals [53]. The study enrolled advanced cancer patients and their informal caregivers (332 dyads) and followed them up to the time of death, a median of 4.4 months later. Quality of life and psychiatric illness was assessed in bereaved caregivers a median of 6.5 months later. Thirty-seven percent of patients reported having end-of-life discussions at baseline. These discussions were associated with lower rates of ventilation, resuscitation, intensive care unit (ICU) admission, and earlier hospice enrollment. Overall, end-of-life discussions were associated with less aggressive medical care near death, better patient quality of life, and earlier hospice referrals [53].

PATIENT WISHES

What do patients consider important in the process of preparing for the end of their lives? How do their perspectives differ from the values of family members or healthcare providers [39]? A 2015 study was conducted to define what matters most about end-of-life care [54]. Providers and administrators from 14 specialized palliative care teams were interviewed and their responses were analyzed to derive themes depicting the universal essence of end-of-life care. The most predominate theme, mentioned by almost one-half of the respondents, was that the "patient's wishes are fulfilled" [54]. Honoring patient wishes involves identifying what a patient wants through open communication and end-of-life care planning, providing education about options, providing realistic expectations, and allowing patients to have control over decision making [54]. Clinicians can regularly promote communication and education about end-of-life care issues by taking the initiative and discussing each patient's goals for end-of-life care. These goals may change over time and with illness and should be regularly re-evaluated and restated [55]. The patient's cultural and/or religious background can influence end-of-life decisions regarding comfort care and patient management, who can be present at the time of death, who will make healthcare decisions, and where the patient wants to die [56]. Encourage patients to elaborate on their wishes with prompts such as [56]:

- "In my religion, we . . ." This will help patients describe religious traditions to be observed at death.
- "Where we come from . . ." This will help patients share important customs to be observed at death.
- "In our family, when someone is dying, we prefer . . ." This will help patients describe what they hope will happen at death.

BARRIERS TO END-OF-LIFE CONVERSATIONS

Barriers to end-of-life discussions can seriously interfere with the quality of remaining life for patients with terminal illness. Barriers have been identified as originating with patients/families, with healthcare professionals, and within the structure of the healthcare system [57].

Patient-Related Barriers

Patients often avoid discussing end-of-life care with their clinicians and may conceal the full extent of what and how they are feeling, given the scope of end-of-life decisions. Family members and significant others also can complicate end-of-life conversations when they either cannot or will not discuss and accept the advanced nature of the patient's disease or the patient's preferences concerning end-of-life care, or when they overestimate the chance of cure, placing unreasonable demands upon the clinician [57].

Clinician-Related Barriers

Clinicians might avoid end-of-life discussions with their patients because they are reluctant to cause pain or be the bearers of bad news. They may lack the necessary communication training and skills, particularly in the delivery of bad news. They may focus solely on clinical parameters or have medical-legal concerns. Clinicians may fear confrontation and/or disagreement with the patient's family, particularly if they feel ill-prepared for such discussions. They may have a lack of confidence in their own judgment of their patient's true condition [57; 58]. Structured and content-based interventions are needed to ensure that critical aspects of the patient's physical, psychological, and spiritual experience are not excluded from care. For healthcare professionals who are delivering bad news, guidelines for the conversation can help give structure and enhance the confidence of the clinician (***Table 2***).

Organizational Barriers

Barriers to end-of-life conversations also originate within the healthcare system. First, end-of-life discussions are not always considered part of routine care; clinicians are not always given the time and structure for discussing end-of-life issues. Next, coordination of these conversations, which becomes more necessary as the patient's illness progresses, may not be included as part of routine care. When patient care is provided by multiple clinicians across multiple sites, there is no clear directive about which clinician should be responsible for initiating and documenting end-of-life conversations. Last, decreased contact time and fewer long-term patient/clinician relationships inhibit end-of-life discussions [57].

No single clinician can successfully undertake all aspects of this challenge. End-of-life planning should be one component of a series of ongoing conversations that together can assist patients with advanced illness to approach death in accord with their own values and wishes. These necessary discussions can draw on the expertise of several disciplines, and the creation of a new professional role specializing in this area might be considered [57].

MENTAL HEALTH INTERVENTIONS FOR END-OF-LIFE CARE

Shortly after Kübler-Ross began to publish her work, group psychotherapists began developing systematic interventions for patients who were dying. This included Irvin Yalom in the 1980s, who was heavily influenced by existential philosophy. Yalom's work formed the basis for what became supportive expressive group psychotherapy (SEGT). SEGT was originally developed to help patients with metastatic breast cancer face

GUIDELINES FOR BREAKING BAD NEWS
Formulate a plan. Mentally rehearse the steps of the conversation.
Schedule a time for the discussion to allow all important family members and medical staff to be present.
Meet in a quiet and private setting.
Make arrangements for a professional translator if English is not the first language of the patient/family. Meet with the professional translator before the discussion to discuss expectations.
Preface bad news with a phrase to prepare the patient or family, such as "I wish the results were different, but…"
Communicate clearly and minimize use of technical language.
Let the patient's and family's reactions guide the flow of the conversation. Allow silence.
Be empathetic and acknowledge the patient's/family's emotions.
Determine the family's level of understanding of the illness/situation to assess misconceptions, aspects of news that will be surprising, and their unique information needs.
Determine if the patient or any family members are "numbers people" so they can be provided the type of information with which they feel most comfortable.
Schedule a future meeting to discuss the bad news and options (e.g., in an hour, the next day, the next week).

Source: [159; 160; 161] *Table 2*

and adjust to their existential concerns (e.g., death, meaninglessness), express and manage disease-related emotions, and enhance relationships with family and healthcare providers. SEGT challenged the thinking that group therapy for patients with terminal illness would be demoralizing [47; 59]. Over the next several decades, research in end-of-life care, patients' end-of-life needs, and the role of mental health professionals in these settings increased [47].

In the late 20th century, physician-assisted death (also referred to as medical aid in dying, physician aid in dying, physician-assisted suicide, or euthanasia) became a topic of interest as researchers sought to understand why some patients with life-limiting illness might want to hasten death [47]. Pain, depression, and physical symptoms were at first thought to be the primary motives behind the desire to hasten death, but literature in the 1990s and 2000s emphasized the psychological and existential correlates (i.e., depression, hopelessness, spiritual well-being) of physician-assisted death. This shift in emphasis led to the development of a number of psychotherapeutic interventions that focused on the psychological and spiritual needs of patients [47].

EVIDENCE-BASED PRACTICE RECOMMENDATION

According to the Institute for Clinical Systems Improvement, short-term psychotherapy modalities (e.g., dignity therapy) can provide reduction in depression and anxiety symptoms at the end of life.

(https://www.icsi.org/wp-content/uploads/2020/01/PalliativeCare_6th-Ed_2020_v2.pdf. Last accessed April 24, 2023.)

Level of Evidence: Expert Opinion/Consensus Statement

DIGNITY MODEL/DIGNITY THERAPY

Dignity therapy was one of the first interventions developed for use in end-of-life care [60]. This modality aims to relieve psycho-emotional and existential distress to improve the experiences of patients with life-limiting illness. It offers patients the opportunity to reflect on what is important to them and on what they might want to communicate to loved ones [61]. In dignity therapy, patients are invited to reflect on and later discuss what aspects of their life they most want recorded and remembered—often referred to as their "legacy" [62]. The sessions are audiotaped and guided by a framework of questions (provided in advance) that facilitate disclosure of the patient's thoughts, feelings, and memories. The interview is then transcribed and printed for the patient's review and editing, as desired. Once finalized, the document is given to the patient, who may (or may not) share with friends and family, as desired. In addition to providing a tangible legacy for the patient, dignity therapy helps enhance the patient's sense of meaning and purpose, thus contributing to a preservation of the patient's dignity [47].

A 2011 study revealed that the items most commonly included in legacy documents were autobiographical information, lessons learned in life, defining roles (e.g., vocations, hobbies), accomplishments, character traits, unfinished business, overcoming challenges, and guidance for others [63]. Dignity therapy has been shown to positively affect patients' sense of generativity, meaning, and acceptance near the end of life. Positive impacts on families and caregivers of dignity therapy participants provide additional support for the clinical utility of this intervention [64]. However, dignity therapy is not for every patient with terminal illness. Despite the demonstrated beneficial effects, its ability to mitigate outright distress (e.g., depression, desire for death or suicidality) has yet to be proven

[65]. Acknowledged limitations of dignity therapy include having adequate time, space, and means to engage in this intervention. Dignity therapy also cannot be used with patients who are nonverbal or unconscious or with those who have severe cognitive limitations [66]. Further studies are needed to determine whether patients with specific types of terminal illnesses (e.g., oncologic, cardiac, renal, pulmonary, neurologic) or in specific age cohorts (e.g., pediatric, adult, geriatric) benefit more or less significantly in certain domains (e.g., measures of spiritual distress, autonomy, death anxiety) [66].

Life Review

Dignity therapy incorporates the concept of life review, which is the systematic and structured process of recalling past events and memories in an effort to find meaning and achieve resolution of one's life. It is conducted over four sessions in which patients chronologically review their childhood, adolescence, adulthood, and present situation. A health or mental health professional takes notes, but no other end product is produced [67]. Life review can be useful for patients of any age at the end of life [68]. Life review is typically structured around life themes (e.g., being a parent/grandparent, first job, life's work, important turning points) [69]. The process can be either reminiscent or evaluative. It also can teach or inform others and pass on knowledge and experience to a new generation. Life review conducted for therapeutic purposes can help patients cope with loss, guilt, conflict, or defeat and find meaning in their accomplishments [69]. In Western culture, life review may subsequently be shared with family or friends. For patients of other cultures, life review may be more communal and may involve rituals that are an important part of the dying process [34]. Few studies have evaluated therapeutic life review interventions, but preliminary results are promising [67].

Narrative Approach

Narrative practice is built on the assumption that people live multistoried lives. This perspective allows patients to shift from one life story to another to give meaning to their lives and shape their identities. A narrative approach frees the care team from the role of "expert" to the role of "helper" who facilitates patients' creation of personal stories of agency at times of life-limiting illness [70]. Narrative therapy is a practical psychotherapeutic process in which the professional and patient collaborate to deconstruct cultural and personal narratives that negatively affect the patient's sense of resources, efficacy, and identity. Together, clinician and patient discover and enrich positive, empowering, and helpful stories that originate in the patient's previous experiences [71]. Narrative therapy is patient-centered and goal-directed. Goals are to help patients improve their sense of self, separate problematic experiences away from their identity, and see themselves outside problems they may be facing. Narrative interventions can help patients and their families create new meaning of the patient's illness and end-of-life experiences [72].

TERROR MANAGEMENT THEORY

The concept of terror management theory was developed in 1986 and was based upon the work of Ernest Becker, a cultural anthropologist who had written about death and anxiety [73; 74]. Terror management theory is the concept that people feel threatened by a deep and terrifying fear of living an insignificant life that is destined to be erased by death. People cope with the awareness of their mortality in different ways. Some will adopt a worldview that allows them to find meaning, purpose, and enduring significance; others simply avoid thinking about death altogether and instead devote themselves to leaving behind a legacy that will make them "immortal" [74; 75]. While the fear of death can promote insecurity and bias or prejudice (based upon one's worldview), terror management theory helps people use their awareness of death to consciously choose to take positive steps to find meaning in their lives [74]. The awareness of mortality can motivate people to prioritize growth-oriented goals, live according to positive standards and beliefs, and foster the development of peaceful, charitable communities [76].

COGNITIVE-BEHAVIORAL THERAPY

The focus of traditional cognitive-behavioral therapy (CBT) is changing maladaptive thought patterns or perceptions that lead to mood disorders, such as anxiety and depression. But changing maladaptive thoughts to more realistic or positive ones does not always meet the needs of patients with life-limiting illness. These patients have very real fears about suffering and uncontrolled pain and other noxious symptoms, and their fears and thoughts are neither maladaptive nor unreasonable [77]. CBT adapted to end-of-life care can help patients identify "all-or-nothing" thinking and help them recognize that core parts of themselves remain unchanged [78].

Studies demonstrate that palliative care professionals have effectively applied CBT techniques to reduce mild-to-moderate anxiety or depression at the end of life and increase the patient's focus on the quality of remaining life [77; 79; 80]. For example, researchers incorporated elements of acceptance and commitment therapy (ACT) and dialectical behavior therapy (DBT). With ACT, patients learn to stop avoiding, denying, and struggling with their emotions. They instead learn to accept their emotions (and the source), accept their private circumstances, and not allow the circumstances to prevent them from moving forward in ways that serve their chosen values [81; 82]. DBT includes a strong educational component designed to provide patients with the skills to manage intense emotions [83].

MEANING-CENTERED PSYCHOTHERAPY

Meaning-centered group psychotherapy, based on the works of Viktor Frankl, was originally conceived as a group-based intervention for individuals with advanced cancer. Frankl's theory is existential in nature and postulates that the creation of meaning is a primary force of human motivation, even during times of great suffering [69]. The group therapy helps patients identify sources of meaning as a resource to sustain meaning, spiritual well-being, and purpose in the midst of suffering [47; 69]. Meaning-centered psychotherapy was later adapted for use with individual patients [84]. The goals of meaning-centered psychotherapy are to provide support for patients to explore personal issues and feelings related to their illness; to help patients identify sources of meaning; and to help patients discover and maintain a sense of meaning in life, even as their illness progresses [47]. Randomized controlled trials conducted to date, totaling nearly 800 patients, have demonstrated support for meaning-centered psychotherapy in improving spiritual well-being and reducing psychological stress in patients at the end of life [85; 86; 87]. The extent to which the observed results can be attributed to the patient's changes in sense of meaning require further study [47]. Like dignity therapy, meaning-centered psychotherapy has fueled multiple adaptations to target unique clinical populations and settings (e.g., bereaved family members, caregivers) [88; 89; 90].

COMPASSION-BASED THERAPY

Compassion-based therapy is rooted in an evolutionary analysis of basic social and emotional systems that motivate humans to live in groups, form hierarchies, help and share through alliances, care for kin, respond to threats, and seek states of contentment/safeness [91]. Compassion-based therapy can be supportive to those facing end-of-life decision making. It is inextricably linked to the inherent values, needs, and expectations of patients, families, and healthcare providers. Compassion coupled with a collaborative framework sustains patient- and family-centered care in end-of-life practice settings [92].

Compassion-based therapy offers a novel, transdiagnostic approach for reducing psychopathology and increasing well-being. It changes the focus of therapy from individual thoughts or unconscious conflicts toward the development of affiliative and prosocial functioning [93]. One overview of compassion-based therapies found at least eight different interventions (e.g., compassion-focused therapy, mindful self-compassion, cognitively based compassion training), six of which have been evaluated in randomized controlled trials. Compassion-based interventions demonstrated reduced suffering and improved life satisfaction for patients [93]. A systematic review conducted to assess the effectiveness of compassion-based therapy analyzed 14 studies, including three randomized controlled studies [94]. Compassion-focused therapy was effective with depressive disorders and for people who are highly self-critical. Compassion-based therapy is most effective when used in conjunction with other types of treatment and therapy [94].

Being Present

One of the most important therapeutic and compassionate aspects a health professional can offer is their presence. Listening to and allowing patients to express their end-of-life experience is healing and can be more comforting than guidance. One study investigated how palliative care chaplains work with patients at the point when it has been decided to cease active treatment, the point at which patients risk losing hope and falling into despair [95]. The author identified four types of presence in the chaplain-patient relationship that were a result of the chaplain's "being with the patient." Each type of presence (i.e., evocative, accompanying, comforting, hopeful) represented a discernable development in the chaplain/patient relationship—a theory of chaplain as hopeful presence [95].

The effects of educating patients and families about the importance of being present was the goal of a descriptive study that included 19 critical care nurses [96]. The nurses were interviewed to understand their experiences and perceptions about caring for patients and families transitioning from aggressive life-saving care to palliative and end-of-life care [96]. The nurses prioritized educating the family, advocating for the patient, encouraging and supporting the family's presence, protecting families, and helping them create positive memories. The family's presence at the end of life also helped them to process the reality of their loved one's death and make peace with it [96].

OTHER INTERVENTIONS

Researchers and clinicians have developed a variety of other interventions for end-of-life care. One proposed treatment is called short-term life review (STLR). Like dignity therapy, STLR interviews the patient for the purpose of creating a legacy album, but STLR differs from dignity therapy in the substance of the interview. A single published randomized controlled trial has examined the utility of STLR, and little research has been conducted to support the STLR approach. The research that has been published has suggested increases in spiritual well-being, sense of hope, and death preparedness among patients with terminal cancer [47; 97; 98].

Managing cancer and living meaningfully (CALM) is a brief, structured intervention developed for patients with advanced and/or terminal cancer [47; 99; 100]. The focus of CALM is similar to meaning-centered psychotherapy, but it provides less emphasis on spiritual well-being and existential issues due to its longer timeframe [47]. The first large-scale randomized controlled trial of CALM reports that individuals demonstrated significantly greater improvements in depressive symptoms and overall quality of life compared to those who received usual care [101].

Mindfulness

Mindfulness is the practice of paying deliberate attention to experiences of the present moment with openness, curiosity, and a willingness to allow things to be as they are [102]. End-of-life care is, by its nature, rooted in mindfulness through [103]:

- The healthcare team providing steady presence and compassion to the dying patient
- Bringing one's full attention to clinical assessments and supportive interactions and acknowledging what arises during these interactions for patients, families, and clinicians
- Being attuned to the dying and their needs, remaining present with their suffering
- Being genuinely interested in the patient's/family's experiences

- Allowing the full expression of personal experiences, with no attempt to change or fix them
- Cultivating compassion and acknowledging our shared humanity

Spiritual Care

Spiritual care is considered a basic tenet of palliative care and a responsibility of the entire end-of-life care team. Patients who receive good spiritual care report greater quality of life, better coping, and greater well-being, hope, optimism, and reduction of despair at the end of life. Despite these benefits, patients and caregivers often refuse spiritual care when offered. One study that sought to understand this reluctance focused on the effect of education. The authors reported that an educational intervention, which included explaining the services of hospice chaplains and the evidence-based benefits of spiritual support, led to greater patient/caregiver acceptance of spiritual care [104]. End-of-life counselors, therapists, and social workers are uniquely positioned to work with patients to explore the variables that they and their families use as guiding principles when making difficult decisions [105]. This requires assessing the patient's spiritual, religious, and existential needs (i.e., spiritual needs) to provide appropriate interventions [106].

The specifics of how to conduct assessment are determined by individual healthcare organizations but usually consist first of obtaining a spiritual history of the patient and the patient's family. A variety of tools are available. The FICA acronym asks four questions about faith, importance/influence of beliefs, community involvement, and addressing issues of care [107]. The HOPE questions inquire about patients' sources of hope and meaning, whether they belong to an organized religion, their personal spirituality and practices, and what effect their spirituality may have on end-of-life care [108]. Reported barriers to spiritual assessment include clinician lack of time/experience, difficulty identifying patients who wish to discuss spiritual beliefs, and addressing concerns not regarded as the clinician's responsibility. Assessing and integrating patient spirituality into end-of-life care can build trust and rapport and strengthen the patient's relationship with the end-of-life care team [108]. Unaddressed spiritual issues may frustrate attempts to treat other symptoms and adversely impact the patient's quality of life [105].

Art and Music Therapy

Art and music therapists are becoming increasingly available to palliative care teams and are advancing the diverse and unique clinical services available to effectively meet the holistic needs of patients with serious illness [109]. Art can connect with deep psychological and physical pain, allowing the patient to find expression and relief. Studies have found that expressive arts (e.g., paint, clay, textiles, drawing) help patients more effectively deal with ambivalent emotions regarding life-death issues and communicate with their families about their feelings. It helps patients articulate their end-of-life journey beyond language [110; 111].

Art therapy also may be helpful in reducing burnout among end-of-life care providers by enhancing their emotional awareness, fostering meaning-making, and promoting reflection on death. One study found significant reductions in exhaustion and death anxiety in end-of-life care providers who participated in an art therapy program [38].

Music therapy incorporates music chosen by the patient in consultation with a qualified music therapist. The music is often chosen to arouse specific emotions that allow the patient to more easily access, recall, and interrogate memories, with the goal of understanding the role those memories play in the patient's current circumstances [38]. Music therapy also may be an effective adjuvant to pain management therapy [38].

BEREAVEMENT

As stated, Kübler-Ross wrote that it could be helpful if people could talk about death and dying as an intrinsic part of life and emphasized the importance of listening as a way for practitioners to support terminally ill patients and their families when confronting the realities of impending death [46; 47]. She subsequently applied her model to the experience of loss in many contexts, including grief and other significant life changes [112]. This model identified five stages of bereavement—denial, anger, bargaining, depression, and acceptance. Though the stages are frequently interpreted strictly and hierarchically, this was not Kübler-Ross's intention. She expressed that individual patients could manifest each stage differently, if at all, and might move between stages in a nonlinear manner [112]. Her model has received criticism in recent years and many alternative models (some based on Kübler-Ross's model) have been developed [112; 113; 114; 115].

PROLONGED GRIEF DISORDER

What are the criteria for the diagnosis of prolonged grief disorder?

The death of a loved one is followed by an intensely emotional and disruptive period that gradually attenuates as the death is comprehended and accepted and its consequences understood (integration). It is a highly stressful period accompanied by the need to attend to a range of things not usually on one's agenda. Most people meet the coping demands and are able to find a pathway through the sorrow, numbness, and even guilt and anger that are part of the normal grieving process. A small minority, however, do not cope effectively. For them, the feelings of loss become debilitating. They do not improve with the passing of time and can become so long-lasting and severe that recovering from the loss and resuming a normal life is impossible without assistance [116]. These people are suffering from prolonged grief disorder, a syndrome in which healing is impeded and acute grief is intense and prolonged.

EVIDENCE-BASED PRACTICE RECOMMENDATION

It is important to differentiate grief from depression. Grieving can be an appropriate response to loss, but if the symptoms persist, the Institute for Clinical Systems Improvement recommends that depression be considered.

(https://www.icsi.org/wp-content/uploads/2020/01/PalliativeCare_6th-Ed_2020_v2.pdf. Last accessed April 24, 2023.)

Level of Evidence: Expert Opinion/Consensus Statement

Prolonged grief disorder is the newest disorder to be added to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The disorder was added to the DSM-5-TR in 2022 after several decades of studies that suggested "many people were experiencing persistent difficulties associated with bereavement that exceeded expected social, cultural, or religious expectations" [117]. Prolonged grief disorder often co-occurs with other mental disorders (e.g., PTSD, anxiety, depression). Sleep problems, such as poor long-term sleep, occur in an estimated 80% of people with this disorder [118].

Prolonged grief disorder is defined as "intense yearning or longing for the deceased (often with intense sorrow and emotional pain) and preoccupation with thoughts or memories of the deceased. In children and adolescents, this preoccupation may focus on the circumstances of the death" [117]. In adults, this intense grief must still be present one year after a loss to be considered prolonged grief disorder; in children, the timeframe is six months. Additionally, the individual with prolonged grief disorder may experience significant distress or problems performing daily activities at home, work, or other important areas [117]. It is important for clinicians to differentiate prolonged grief disorder from usual acute grief, as well as depression and anxiety disorders [116]. Risk factors for prolonged grief disorder include past losses, separations that can impact current losses, and a history of depressive illness [115]. Symptoms include [117]:

- Identity disruption (e.g., feeling as though part of oneself has died)
- A marked sense of disbelief about the death
- Avoidance of reminders that the person is dead
- Intense emotional pain (e.g., anger, bitterness, sorrow)
- Difficulty reintegrating (e.g., unable to engage with friends, pursue interests, plan for the future)
- Emotional numbness
- Feeling that life is meaningless
- Intense loneliness and feeling of being detached from others

An estimated 7% to 10% of bereaved adults will experience the persistent symptoms of prolonged grief disorder, and 5% to 10% of bereaved children and adolescents will experience depression, PTSD, and/or prolonged grief disorder [118; 119]. Treatments using elements of CBT have been found to be effective in reducing symptoms [117]. Complicated grief treatment incorporates components of CBT and other approaches to help patients adapt to the loss. It focuses on accepting the reality of the loss and on working toward goals and a sense of satisfaction in a world without the loved one [118]. Research has shown that CBT is effective in addressing sleep problems associated with prolonged grief disorder. CBT also has been shown to be superior in long-term effects to supportive counseling in children and adolescents experiencing symptoms of prolonged grief disorder [119; 120].

Bereavement support groups can provide a useful source of social connection and support. They can help people feel less alone, thus helping to avoid the isolation that could increase the risk for prolonged grief disorder. Despite the existence of effective treatments, people experiencing prolonged grief disorder may not seek help. One study of 86 bereaved caregivers with symptoms of prolonged grief disorder found that only 43% accessed mental health services [121].

PRACTICAL, ETHICAL, AND LEGAL CONSIDERATIONS

Planning ahead provides patients with the most control over their end-of-life care, but not all patients have the opportunity to do so. End-of-life planning for the patient will include knowing the type of care they need and want, knowing where they want to receive this care, knowing what documents (e.g., advance directives) and associated costs to include in planning, and determining who will help carry out their wishes [122].

CAREGIVING AND SURROGACY

The vast majority (80%) of care given to hospice patients is provided by informal and unpaid caregivers who are often family members. They can be responsible for everything from the management of household and finances to medical and personal care. Providing this level of care can contribute to increased stress and health problems [123]. Caregivers often report significant levels of anxiety, depression, and perceived stress as well as poorer physical health and decreased quality of life compared with non-caregivers [124]. In one study, nearly one-third (31%) of caregivers reported moderate-to-high levels of anxiety [125]. Even family members who are not caregivers experience distress and require support. Supporting the growing number of family and other unpaid caregivers is an urgent public health issue. The need for adequate support is especially pressing when older patients and the loved ones who assist them are most vulnerable, as at the end of life [126]. Health and mental health professionals can help the caregiver and/or family by preparing them for their loved one's death, treating symptoms of burnout and stress, and offering grief counseling when desired [127].

Family members may be called upon to make decisions on their loved one's behalf if incapacitation becomes an issue. Ideally, the decision-making process will reflect the patient's physiologic realities, preferences, and recognition of what, clinically, may or may not be accomplished [128; 129]. Being a surrogate decision maker is stressful for many and can have negative emotional effects that last months or years [130]. Frequent tension can occur between the desire to respect the patient's values and the fear of responsibility for a loved one's death, a desire to pursue any chance of recovery, and a need to ensure family well-being [131]. Counseling for the surrogate both during and after the decision-making process can be beneficial.

Shared decision making also has been found to be beneficial. Healthcare providers can encourage decision makers to involve other family members. They can repeat relevant information in simple language, prompt them to think about what the patient would or would not want, and frequently remind them that everything that can be done is being done [132]. Support for the surrogate should foster respect for patient preferences and values and help reduce guilt about decisions made following the patient's death [132]. An ideal surrogate will participate in collaborative decision-making with care providers. If a surrogate avoids communication or requests interventions that are clearly not considered in the patient's best interest, counseling should be provided. If counseling is unsuccessful, replacement of the surrogate should be considered [133]. Family members who reside far away and who are not designated as decision maker also can create difficulties by trying to undo, contest, undermine, or alter decisions made by local family members who have long been involved in the patient's care. These disagreements can compromise the ability of the patient's healthcare team to provide quality care. These limits of formal advance care planning have led some practitioners to assert that informal conversations with patients' significant others are most critical to end-of-life planning [134].

Current practice frequently fails to promote patient goals. This is an area for future research and improvement. In the meantime, clinicians should encourage patients to document their own goals, including treatment preferences and preferences regarding how they want decisions to be made for them during periods of decisional incapacity. This is achieved through advance care planning [135; 136].

ADVANCE CARE PLANNING

Advance care planning is widely considered an essential step toward achieving end-of-life care that is consistent with the preferences of dying patients and their families. Advance care planning typically includes a living will and a durable power of attorney for health care, which enable patients to articulate and convey their treatment preferences while they are cognitively intact [136]. Advance care planning documents also can include do not resuscitate (DNR) orders, medical/physician order for life-sustaining treatment (MOLST/POLST), and informal documents of preference or other healthcare proxies. Ideally, these documents reflect discussions among the patient's family, surrogate, and healthcare provider about the patient's preferences for health care in the context of serious illness [129]. Advance care planning is considered an essential step for achieving a "good death" in which physical pain and emotional distress are minimized and the patient's and family members' treatment preferences are respected [134]. Advance care planning is associated with greater use of palliative care among dying patients, lower medical expenditures at the end of life, and less distress among patients and patients' families.

Race and socioeconomic disparities in rates of advance care planning have been documented. Policy advances (e.g., Medicare reimbursement for doctor-patient consultations) may increase rates of planning among populations who may not have access to professionals who encourage such preparations [136]. Health and mental health professionals can assist families in the process of preparing advanced care planning documents. Being a mediator in advance care planning conversations can provide clarity for patients and family members about the patient's wishes regarding death [137].

ETHICAL/LEGAL ISSUES

Ethical concerns and legal considerations can influence counseling at the end of life. Health and mental health providers are on the frontline supporting and guiding the patient and the patient's family through the dying process.

Autonomy

Autonomy, as viewed from the perspective of patients at the end of life, includes two core domains: "being normal" and "taking charge" [138]. These two domains account for the circumstances and clinical realities of people with life-limiting illness and allow clinicians to better understand their needs. Autonomy is, however, not just a concern when making choices of treatment for end-of-life care but also when supporting patients in their daily lives and active preparations for dying. This support can help relieve the patient of stress and the fear of being a burden to family [138]. When a patient expresses a fear over the loss of autonomy, it is important for clinicians to determine the source of the fear. Common sources of such fear include fear of becoming physically dependent on life-supporting technology; fear of losing independence; and fear of loss of engagement in meaningful activity. Often, the patient is simply expressing a desire to preserve self-determination regarding end-of-life care and planning [45]. The healthcare team respects patients' autonomy by giving them the information needed to understand the risks and benefits of a proposed intervention, as well as the reasonable alternatives (including no intervention), so that they may make independent decisions [139].

Distributive Justice

Distributive justice is the fair, equitable, and appropriate distribution of healthcare resources. It requires impartiality in the delivery of health service. Issues of distributive justice encountered in healthcare settings include the allotment of scarce resources, care of uninsured patients, conflicts of interest based on religious or legal grounds, and public health and safety issues. Despite these constraining influences, healthcare providers have an ethical obligation to advocate for fair and appropriate treatment of patients at the end of life [140; 141].

Beneficence

The principle of beneficence is the obligation of health and mental health professionals to act in the best interest of the patient [137]. Beneficence also includes preventing and avoiding harm and defending the most useful intervention for the patient [140; 141]. Beneficence is fundamental to dilemmas about the discontinuation, withholding, or withdrawal of medical treatment [137]. When wishes about end-of-life care are not known or cannot be communicated by the patient, end-of-life decisions should be made by the healthcare team as a result of consultations with the family or healthcare proxy [137].

Nonmaleficence

Nonmaleficence is the principle of refraining from causing unnecessary harm (i.e., first, do no harm) [137]. It also refers to the moral justification behind an intervention that might cause some pain or harm; harm is justified if the benefit of the intervention is greater than the harm to the patient and the intervention is not intended to harm [137]. The emphasis in nonmaleficence is on relieving the symptoms that harm the patient [142]. Health and mental health providers can exercise nonmaleficence by having an understanding of the moral principles and ethical codes governing end-of-life care. They can prevent undue harm by being as knowledgeable as possible about impending illnesses through relationships with the interprofessional team [137].

CULTURALLY COMPETENT CARE AT THE END OF LIFE

What is the role of interpreters at the end of life?

The clinician/patient discussion about end-of-life care is often a challenge and one that can be further complicated when the patient's cultural norms differ from that of the clinician. As discussed, values of medical care emphasize autonomy and individual rights to make life choices [143]. The Patient Self Determination Act of 1990 ensured that those rights are protected. This includes the rights to treatment choices, informed consent, truth-telling, open communication with healthcare providers, and control over the individual's own life and death [143; 144]. However, these core values may be in conflict with the values of many ethnic and culturally diverse groups in the United States and may lead to health disparities, fragmented care, inadequate or inappropriate symptom management, miscommunication with the patient and family, and a difficult and poor death for the patient [143].

EVIDENCE-BASED PRACTICE RECOMMENDATION

The Institute for Clinical Systems Improvement asserts that clinicians caring for patients with serious illness should examine their own cultural values and assumptions about what constitutes "good" care for patients nearing the end of life, recognizing not all patients will share these same values, and ensure goals and decisions remain centered around the patient's values/beliefs.

(https://www.icsi.org/wp-content/uploads/2020/01/PalliativeCare_6th-Ed_2020_v2.pdf. Last accessed April 24, 2023.)

Level of Evidence: Expert Opinion/Consensus Statement

Enhanced cultural competency in end-of-life issues continues to be identified as a need for clinicians who provide care for patients at the end of life [143]. Healthcare providers should understand and recognize the specific influences that culture has on a patient's behavior, attitudes, preferences, and decisions about end-of-life care. It is important to note that a patient's identification as a member of a particular ethnic group or religion does not necessarily mean that the patient or patient's family adheres to beliefs associated with that ethnicity or religion [143]. Other factors (e.g., age, race, sex, ethnicity, health status, religion) also can influence how patients approach the end of life, and their cultural and religious backgrounds influence their definitions of and perceptions about what constitutes quality of life, suffering, and pain [145].

Other areas of end-of-life care that vary culturally include the method used for communicating "bad news," the locus of decision making, and attitudes toward advance directives and end-of-life care specifics [146]. In contrast to the emphasis on "truth telling" in the United States, it is not uncommon for healthcare professionals outside the United States to conceal serious diagnoses from patients, because disclosure of serious illness may be viewed as disrespectful, impolite, or even harmful to the patient. The emphasis on patient autonomy may conflict with the patient's preferences for family-based, physician-based, or shared family-physician-based decision making. Lower rates of completion of advance directives by patients of some ethnic backgrounds suggests a distrust of the healthcare system, healthcare disparities, and underutilization of health care [146; 147; 148].

An assessment should be made of how acculturated a patient and family are, their language skills, and whether an interpreter is needed [143]. The clinician should assess for [149]:

- Openness/willingness of the patient/family to discussing/accepting the diagnosis, prognosis, and death
- How decisions are made and what influences decision making (e.g., age, gender, hierarchy, quality of interfamily communication)
- What does physical pain mean and how should it be managed?
- Is there spiritual pain? Does the patient desire the help of a spiritual advisor? Does the patient/family want time and space for praying, meditation, and other rituals?
- The relevance of religious beliefs regarding the meaning of death
- How the body should be handled following death

The clinician also can take advantage of available resources, including community or religious leaders, family members, and language translators [149]. It is important to note that using professional interpreters for patients and with limited English proficiency will help ensure quality care. Convenience and cost lead many clinicians to use "ad hoc" interpreters (e.g., family members, friends, bilingual staff members) instead of professional interpreters. However, professional interpreters are preferred for several reasons. Several states have laws about who can interpret medical information for a patient, so healthcare professionals should check with their state's health officials about the use of ad hoc interpreters [150]. Even when allowed by law, the use of a patient's family member or friend as an interpreter should be avoided, as the patient may not be as forthcoming with information and the family member or friend may not remain objective [150]. Children should especially be avoided as interpreters, as their understanding of medical language is limited, and they may filter information to protect their parents or other adult family members [150]. Individuals with limited English language skills have actually indicated a preference for professional interpreters rather than family members [151].

Also important is the fact that clinical consequences are more likely with ad hoc interpreters than with professional interpreters [152]. A systematic review of the literature showed that the use of professional interpreters facilitates a broader understanding and leads to better clinical care than the use of ad hoc interpreters, and many studies have demonstrated that the lack of an interpreter for patients with limited English proficiency compromises the quality of care. The use of professional interpreters improves communication (errors and comprehension), utilization, clinical outcomes, and patient satisfaction with care [151; 153]. One review of case studies regarding professional interpretation noted that "patients with limited English proficiency in the United States have a legal right to access language services, and clinicians have legal and ethical responsibilities to communicate through qualified interpreters when caring for these patients" [154].

Culturally competent counseling for patients at the end of life begins with understanding their differing cultural, religious, and other important influential factors. It involves listening to and learning about patients' varying attitudes, preferences, and practices in order to integrate them into an appropriate plan of care [155]. Clinicians should treat all patients with dignity, respecting their rich cultural traditions and incorporating them into the plan of care. It means communicating with the patient and the patient's family in advance about how the plan of care is aligned with their beliefs, concerns, values, and preferences [145]. To deny the expression of different cultural worldviews in the context of end-of-life care would be to rob patients of the security and serenity that their cultural beliefs give them when faced with uncertainty and fear [156].

CONCLUSION

Health and mental health professionals provide services to diverse individuals in a variety of settings, including end-of-life settings, as part of an interprofessional team. In the end-of-life setting, these professionals help dying patients and their families prepare for death with education and supportive therapeutic interventions that address the patient's physical, emotional, social, spiritual, and practical needs using a patient-centered, culturally sensitive approach [10; 157]. Clinicians can regularly promote communication and education about end-of-life care issues by taking the initiative and discussing each patient's goals for end-of-life care [55]. The better informed the patient and family are, the more likely their decisions about end-of-life care will reflect their beliefs, values, and the best interests of the patient. This means having difficult conversations. All professionals should work to become comfortable with the most uncomfortable of topics. This work is not done alone. It is essential to lean on and consult colleagues and other members of the care team. End-of-life care often involves interactions between caregivers and various professionals (e.g., physicians, nurses, social workers, mental health professionals, clergy) who have distinct roles in preparing caregivers for the patient's death [158]. Aligning on key concepts and approaches to care can help to ensure that the best possible care and support are given at the end of life.

Customer Information/Evaluation insert located between pages 16–17.

COURSE #95300 — 8 CONTACT HOURS Release Date: 05/01/23 Expiration Date: 04/30/26

Substance Use Disorders and Pain Management

Includes 8 Pharmacotherapeutic/Pharmacology Hours

This course meets the Texas APRN requirements for pain management and opioid/controlled substance education.

This course meets the Federal MATE Act requirement for 8 hours of training for APRNs with a new or renewing DEA license. This course may be completed for general CE.

Audience

This course is designed for all healthcare professionals who may alter prescribing practices or intervene to help meet the needs of patients with substance use disorders.

Course Objective

The purpose of this course is to provide clinicians who prescribe or distribute controlled substances with an appreciation for the complexities of managing patients with substance use disorders and comorbid pain in order to provide the best possible patient care and to prevent a growing social problem.

Learning Objectives

Upon completion of this course, you should be able to:

1. Outline substance use disorder risk factors, screening, and diagnosis.
2. Describe the role of psychosocial therapies in the management of substance use disorders.
3. Compare and contrast available pharmacotherapeutic options for the treatment of alcohol, tobacco, and opioid use disorders.
4. Discuss the impact of polysubstance use and co-occurring mental disorders and substance use disorder presentation and treatment.
5. Review legal and ethical issues related to substance use disorder treatment.
6. Create comprehensive treatment plans for patients with pain that address patient needs as well as drug diversion prevention.
7. Evaluate behaviors that may indicate drug seeking or diverting as well as approaches for patients suspected of misusing opioids.
8. Identify state and federal laws governing the proper prescription and monitoring of controlled substances.

Faculty

Mark Rose, BS, MA, LP, is a licensed psychologist in the State of Minnesota with a private consulting practice and a medical research analyst with a biomedical communications firm. Earlier healthcare technology assessment work led to medical device and pharmaceutical sector experience in new product development involving cancer ablative devices and pain therapeutics. Along with substantial experience in addiction research, Mr. Rose has contributed to the authorship of numerous papers on CNS, oncology, and other medical disorders. He is the lead author of papers published in peer-reviewed addiction, psychiatry, and pain medicine journals and has written books on prescription opioids and alcoholism published by the Hazelden Foundation. He also serves as an Expert Advisor and Expert Witness to law firms that represent disability claimants or criminal defendants on cases related to chronic pain, psychiatric/substance use disorders, and acute pharmacologic/toxicologic effects. Mr. Rose is on the Board of Directors of the Minneapolis-based International Institute of Anti-Aging Medicine and is a member of several professional organizations.

Faculty Disclosure

Contributing faculty, Mark Rose, BS, MA, LP, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the study questions and course material for better application to your daily practice.

INTRODUCTION

Substance use disorders continue to be an important health issue in the United States. The fifth edition (text revision) of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR) includes criteria for substance use disorder involving alcohol; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, or anxiolytics; stimulants; tobacco (nicotine); and other (or unknown) substances [1]. Excluding tobacco use disorder, the most common substance use disorders in the United States are [2]:

- Alcohol use disorder (29.5 million)
- Cannabis use disorder (16.3 million)
- Prescription opioid use disorder (5.0 million)
- Methamphetamine use disorder (1.6 million)

Substance use disorders can lead to significant problems in all aspects of a person's life, and appropriate assessment and management of substance use is a priority in patient care.

The presence of substance use disorders can complicate the treatment or management of comorbid medical conditions. Given the ongoing prescription opioid (and illicitly manufactured fentanyl) use and overdose epidemic in the United States and the widespread incidence of chronic pain, opioid prescribing and optimum safe pain management is a public health concern. All clinicians should have good knowledge of the available options for substance use disorder treatment and for safe opioid prescribing and dispensing.

Coordinated care is critical to achieve positive outcomes. Coordinating treatment for comorbidities, including mental health conditions, is an important part of treating substance use disorders and pain alike.

SUBSTANCE USE DISORDER SCREENING AND DIAGNOSIS

According to the 2021 National Survey on Drug Use and Health, 46.3 million Americans 12 years of age or older had a substance use disorder in the past year [2]. Substance use disorders are treatable, chronic diseases characterized by a problematic pattern of use of a substance or substances leading to impairments in health, social function, and control over substance use. It is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite harmful consequences. These disorders range in severity and can affect people of any race, gender, income level, or social class.

RISK FACTORS

What are risk factors for the development of a substance use disorder?

Researchers who study risk factors have developed models of how known risk factors may interact to create pathways that lead to substance use disorders. Of course, not all persons who use drugs regarded as having a high liability of misuse end up becoming addicted to the drug.

Genetic Predisposition

Research has shown that genetic factors play a strong role in whether a person develops a substance use disorder, accounting for 40% to 60% of the risk [3; 4; 5]. In fact, family transmission of substance use disorder, particularly alcohol use disorder, has been well established. Individuals who have relatives with substance use disorder are at three- to five-times greater risk of developing substance use disorder than the general population. The presence of substance use disorder in one or both biologic parents is more important than the presence of substance use disorder in one or both adoptive parents. The genetic risk increases with the number of relatives with substance use disorder and the closeness of the genetic relationship [5]. However, most children of parents with substance use disorder do not develop disorders, and some children from families where substance use is not a problem develop disorders when they get older.

Children with Conduct Problems

One model focuses on children who have temperaments that make it difficult for them to regulate their emotions and control their impulses. Clearly, these children are difficult to parent, and if one or both of their parents have a substance use disorder, it is likely that they will be poorly socialized and have trouble getting along in school [6; 7]. Poor academic performance and rejection by more mainstream peers at school may make it more likely for these children to join peer groups where drinking and other risky behaviors are encouraged. Parents with substance use disorders will likely not monitor their children closely and will lose control over them at an early age. These children will begin using substances early, often before 15 years of age [8]. If such a child is genetically predisposed to substance use disorders, these environmental factors may further increase the tendency [9].

Stress and Distress

Another model of risk factors leading to substance use disorder focuses on substance use to regulate inner distress [10]. Some children have temperaments that make them highly reactive to stress and disruption. Regardless of the child's family environment, he or she maintains higher levels of inner distress (anxious and depressed feelings) than other children. When they first drink or use a substance, the inner distress dissipates for a while. This leads to more substance use and may lead to substance use disorder. More research is required before the role of stress as a risk factor in alcohol use disorders is understood.

Adverse childhood experiences, particularly sexual abuse, family rejection, and parental neglect, are independent risk factors for substance use disorders [11]. Adverse childhood experiences are linked with depression in adulthood, which itself is a risk factor for substance use disorder. This correlation can be modulated by resilience, which can also be a result of adverse childhood experiences.

Other Mental Disorders

Mental disorders can contribute to substance use and substance use disorders. Certain psychiatric disorders, including anxiety, depression, or post-traumatic stress disorder, have been linked to substance misuse, likely a form of self-medication. Additionally, brain changes in people with mental disorders may enhance the rewarding effects of substances, making it more likely they will continue to use the substance [12].

Environmental Stimuli

The expected drug effect and the setting of use (context of administration) play important roles in the social learning of drug use. Opioids and other drugs that increase dopamine turnover lead to conditional responses, and use may become conditioned to the activities of daily living. As a result, environmental stimuli can become powerfully associated with substance use, which can trigger cravings for the drug [13]. The visibility of pharmaceutical marketing and advertising of medications may also play a role by changing the attitudes toward ingestion of these agents [13]. For youth, a social learning aspect to drug use is likely, based on the modeling of drug use by adults in their families and social networks [13].

SCREENING AND ASSESSMENT TOOLS CHART

Tool	Substance Type		Patient Age		Administration Method	
	Alcohol	Drugs	Adults	Adolescents	Self-Administered	Clinician-Administered
Screening Tools						
Screening to Brief Intervention (S2BI)	X	X		X	X	X
Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD)	X	X		X	X	X
Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)	X	X	X		X	X
Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (NIAAA)	X			X		X
Opioid Risk Tool – OUD (ORT-OUD) Chart		X	X		X	
Assessment Tools						
Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)	X	X	X		X	X
CRAFFT	X	X		X	X	X
Drug Abuse Screen Test (DAST-10)[a]		X	X		X	X
Drug Abuse Screen Test (DAST-20: Adolescent version)[a]		X		X	X	X
Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (NIAAA)	X			X		X

[a]Tools with associated fees

Source: [14] *Table 1*

SCREENING

A variety of screening and assessment tools are available, with applicability for various substances, patient populations, and screening environments (***Table 1***).

The Tobacco, Alcohol, Prescription medication, and other Substance Use (TAPS) Tool is validated for use with adults to generate a risk level for each substance class. It can be self-administered or conducted via clinician interview and combines screening and brief assessment of past 90-day problematic use into one tool [14]. The TAPS Tool has two components. The first component (TAPS-1) is a four-item screen for tobacco, alcohol, illicit drugs, and non-medical use of prescription drugs. If an individual screens positive on TAPS-1 (i.e., reports other than "never"), the tool will automatically begin the second component (TAPS-2), which consists of brief substance-specific assessment questions to arrive at a risk level for that substance. Clinicians are encouraged to provide positive feedback to patients who screen negative and support their choice to abstain from substances. The tool can be accessed online at https://nida.nih.gov/taps2/#/.

DIAGNOSIS

As noted, the DSM-5-TR defines substance use disorder as a problematic pattern of substance use, leading to clinically significant impairment or distress. While criteria are outlined for specific substances in the DSM-5-TR, the components are generally the same regardless of substance used. The diagnosis of substance use disorder is made by meeting two or more criteria in a one-year period [1]:

- Substance taken in larger amounts or over a longer period than was intended
- A persistent desire or unsuccessful efforts to cut down or control use
- Excessive time spent to obtain, use, or recover from using the substance

- Craving, an intense urge to use
- Substance use interferes with obligations
- Continued use despite life disruption
- Reduction or elimination of important activities due to use
- Recurrent use in physically hazardous situations
- Continued use despite physical or psychologic problems
- Tolerance
  - Need for increased doses of the substance for the desired effect
  - A markedly diminished effect with continued use of the same amount
- Withdrawal

In the case of opioid use disorder, the criteria for tolerance and withdrawal are not considered to be met for those taking opioids solely under appropriate medical supervision.

SUBSTANCE USE DISORDER TREATMENT

All substance use disorder treatment plans should reflect the patient's most important goals and establish measurable and achievable steps toward achieving those goals. As such, all treatment plans will be individualized and created in collaboration with the patient. This recovery roadmap also requires that clinicians communicate with clear, nonstigmatizing language regarding the patient's condition and options.

TREATMENT PLANNING

Assessing Readiness to Change

Readiness to Change is Dimension 4 of the American Society of Addiction Medicine's (ASAM's) Six Dimensions of Multidimensional Assessment (also known as the ASAM Criteria) that is the standard for placement, continued stay, transfer, or discharge of patients with substance use disorder and co-occurring conditions [15]. Several factors influence a person's readiness and ability to change behaviors. It is useful to help patients to weigh the risks of continued substance use and benefits of decreasing or eliminating substance use. Healthcare professionals can help motivate the patient to become ready for treatment if the patient appears ready to change.

Is the patient ready to change? The role of motivation is an important part of changing behavior.

Motivational Interviewing

Motivational interviewing is a method of counseling designed to enhance patients' motivation to change by helping them explore and resolve their ambivalence about making the change [16]. It is a collaborative, non-confrontational, "guiding" approach. In substance use disorder, motivational interviewing utilizes active listening to understand how the patient feels about his or her substance use in an effort to uncover any ambivalence [17]. The healthcare provider elicits the patient's own views regarding consequences of continuing to use and benefits of quitting and asks permission to share additional information on risks when necessary. Goals are developed collaboratively, based on the patient's current readiness to change. Originally developed as an intervention for alcohol use disorder, it has shown promise as a successful strategy for other substances as well.

PSYCHOSOCIAL THERAPY

Treatment of substance use and dependence with psychosocial or behavioral therapy is based on the assumption that addictive behavior is developed and maintained by specific mechanisms [18]:

- Expectancies and modeling
- Reinforcing properties of the drug
- Secondary social reinforcement

The goal of these types of treatments is to modify drug-seeking and other behavioral aspects of drug dependency [19]. Psychosocial therapy and pharmacotherapy are not mutually exclusive; in fact, some drug therapies for substance abuse are considered useless without a psychosocial/behavioral component [18; 19].

Psychosocial therapies for substance use disorders can be divided into two broad categories. The first category consists of therapies that were originally developed for patients with anxiety and depression and modified for use with patients with substance use disorders. This group of therapeutic approaches includes cognitive-behavioral therapy (CBT), the behavioral therapies, and interpersonal therapy. The second group of psychosocial therapies was developed explicitly for patients with substance use disorders and includes motivational interviewing and motivation enhancement therapy [19; 20]. All psychotherapies are intended to be delivered in a supportive, empathic manner that minimizes confrontation.

EVIDENCE-BASED PRACTICE RECOMMENDATION

For patients with alcohol use disorder, the Department of Veterans Affairs Work Group recommends offering one or more of the following interventions, considering patient preference and provider training/competence:

- Behavioral couples therapy for alcohol use disorder
- Cognitive-behavioral therapy for substance use disorders
- Community reinforcement approach
- Motivational enhancement therapy
- 12-step facilitation

(https://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPG.pdf. Last accessed April 27, 2023.)

Strength of Recommendation: Strong for

Drug counseling is a widely used therapy approach with patients with substance use disorders. It consists of a focus on abstinence, problem solving, and 12-step orientation and involvement. Drug counseling is usually provided by counselors who have a certificate in addiction counseling. A fair number of addiction counselors are themselves recovering from alcohol and/or substance use disorders [20].

Contingency Management

There is considerable evidence that substance use is sensitive to the application of contingencies. Contingencies occur on a spectrum from contrived to naturalistic. Contingency management and vouchers are examples of contrived interventions, while 12-step programs are examples of naturalistic interventions [21]. Contrived contingencies may be effective in initially engaging patients in abstinence, but relapse to drug use may occur following removal of the reinforcer. In contrast, naturalistic contingencies are more likely to maintain the initial gains made by the patient and to facilitate the sustained change of behavior over time [22].

The goal of contingency management interventions is to increase the opportunity cost of substance use by arranging an environment where drug use results in the forfeiture of a predetermined item or privilege, referred to as an alternate reinforcer [23]. Treatment with a contingency management component was first used with cocaine-abusing methadone patients, a highly suitable population for two reasons: cocaine abuse is prevalent among patients with opioid use disorder receiving methadone maintenance, and methadone patients are required to report to the clinic daily to receive their medication under staff supervision. Daily clinic appointments are often considered a significant constraint on employment, travel, and other activities. Patients who are able to abstain from drugs of abuse, as measured by a urine drug screen, may be allowed several days of take-home methadone doses, which can act as a behavioral contingent [24]. Several studies have shown that this contingent condition has led to greater treatment retention and reductions in cocaine use than those found in comparison treatment conditions, although this effect dissipates with longer-term follow-up [22; 25; 26; 27].

Community Reinforcement

Community reinforcement approaches are biopsychosocial interventions designed to engage and change the lifestyle of the drug abuser by addressing the role of environmental cues and alternative reinforcers in influencing behavior. The theoretical basis of the community reinforcement approach is that substance abuse is maintained by substance-related reinforcers as well as by the absence of competing alternative reinforcers. The primary goal of the community reinforcement approach is to build and strengthen relationships, recognize appropriate leisure activities, and identify vocational interests of the patient to provide competing reinforcement with substance use and the drug-using lifestyle [28]. The community reinforcement approach aims to increase abstinence by increasing or highlighting the opportunity cost of relationships and social support the patient stands to lose through drug use [22]. In addition to integrating cognitive-behavioral and, in some cases, pharmacologic approaches, community reinforcement approaches may also include the use of vouchers, whereby tokens are given to the patient for producing substance-free urine samples, which are then used to purchase goods and services desired by the patient.

A review of four studies utilizing a community reinforcement approach with patients with substance use disorder found evidence that a community reinforcement approach employing abstinence-contingent incentives in the form of vouchers was more effective in promoting abstinence than community reinforcement approaches using noncontingent incentives and usual care. Patients assigned to community reinforcement incorporating abstinence-contingent incentives experienced a greater reduction in disease severity as measured by the Addiction Severity Index than comparison groups [28]. Despite early, promising reports of community reinforcement with patients with alcohol use disorder and evidence that patients receiving community reinforcement approaches have demonstrated more favorable drug use outcomes than patients receiving standard outpatient counseling, a community reinforcement approach is seldom used because of the relatively high cost and labor intensity [19; 29].

Motivational Interventions

Motivational interventions for substance use disorders stem from the theory that targeting and enhancing motivation to quit drugs will increase positive outcome; positive outcome is increased when motivation comes internally rather than when it is externally imposed. Specifically, motivational enhancement therapy is based on the Transtheoretical Stages of Change Theory, which postulates that patients pass through a series of stages of thought, planning, and action in the process of behavior change [30]. Motivational enhancement therapy is intended to enhance motivation and commitment to change, activate patient resources, and facilitate movement along the readiness-to-change spectrum [31]. Motivational enhancement therapy helps patients build internal motivation through the resolution of issues related to ambivalence. The therapeutic approach is characterized by nonconfrontive, nonjudgmental interviewing that helps the patient consider the pros and cons of change. Motivational enhancement therapy also strives to enhance patient self-efficacy [30]. Motivational enhancement therapy seems to be more effective in patients with low initial levels of motivation when used for patients with substance use disorder. It tends to result in less relapse to use and fewer total days of use [32].

Coping and Social Skill Training

What are the primary areas addressed by coping and social skill training (CSST)?

Coping and social skill training (CSST) evolved from social learning theory and is used to improve the inadequate coping skills found in many persons with substance use disorders, including deficits in regulation of emotion and in effectively coping with social situations. CSST addresses four primary areas [33]:

- Interpersonal skills
- Cognitive and affective regulation
- Coping skills to manage stressful life events
- Coping skills when substances or substance-related cues are encountered

An added emphasis on drug-related cues is used when CSST is employed with patients with certain substance use disorders (e.g., cocaine, opioids) [33].

CSST has incorporated these findings into the treatment approach used with patients with substance use disorders. Preliminary results indicate some benefit of substance-specific CSST in reducing frequency of substance use and increasing duration of abstinence, although these results have not been replicated in subsequent research [32; 33].

Drug Counseling

CBT is among the most frequently evaluated approaches used to treat substance use disorders [34; 35]. CBTs have been shown to be effective in several clinical trials of substance users [36]. Characteristics of CBTs include:

- Social learning and behavioral theories of drug abuse
- An approach summarized as "recognize, avoid, and cope"
- Organization built around a functional analysis of substance use (i.e., understanding substance use with respect to its antecedents and consequences)

Skill training focused on strategies for coping with craving, fostering motivation to change, managing thoughts about drugs, developing problem-solving skills, planning for and managing high-risk situations, and cultivating drug refusal skills

Basic principles of CBTs are that [37; 38]:

- Basic skills should be mastered before more complex ones are given.
- Material presented by the therapist should be matched to patient needs.
- Repetition fosters the development of skills.
- Practice is needed for mastery of skills.
- The patient is an active participant in treatment.
- Skills taught are general enough to be applied to a variety of problem areas.

Structured behavior therapy techniques can be effective components of substance use disorder treatment. Contingent incentive procedures are designed to enhance a patient's motivation to meet treatment goals by offering concrete rewards for specific performance outcomes.

Behavioral therapy techniques are often part of CBT. In this approach, substance use is believed to develop from changes in behavior and a reduction in opportunities for reinforcement of positive experience. The goal is to increase the person's engagement in positive or socially reinforcing activities. Techniques such as having patients complete a schedule of weekly activities, engaging in homework to learn new skills, role-playing, and behavior modification are used. Activity, exercise, and scheduling are major components of this approach based on the following:

- Patients with substance use disorders require motivation and skills to succeed in stopping drug use.
- Research has shown that drug abuse behavior can be reduced by offering contingent incentives for abstinence.
- The most striking successes have come from positive reinforcement programs that provide contingent incentives for abstinence using money-based vouchers as rewards.
- Research provides examples, but treatment providers may need to be creative in discovering reinforcers that can be used for contingency management in their own clinical settings.

Family therapy is a highly effective treatment for alcohol use disorder, especially in adolescents. While most treatments emphasize the individual as the target of intervention, the defining characteristic of family therapy is the transformation of family interactions. Repetitive patterns of family interactions are the focus of treatment. Changing these patterns results in diminished antisocial behavior including alcohol abuse. Family therapy can work with a broad range of family and social network populations. Family therapy approaches have developed specific interventions for engaging and keeping reluctant, unmotivated adolescents and family members in treatment.

PHARMACOTHERAPY FOR DETOXIFICATION AND ABSTINENCE

A variety of medications have been approved to assist in cessation of the use of opioids, alcohol, and nicotine (***Table 2***). Any time pharmacotherapy is initiated, is important that a collaborative, patient-centered approach is undertaken, with all members of the care team working together to best meet the needs of the specific patient. Unique, individual physiology and metabolism can impact medication pharmacodynamics; this should be considered in each treatment plan.

Alcohol Use Disorder

Several medications are available to help treat alcohol use disorder [40; 41]. Some are used for detoxification and others are used to prevent relapse. Research has shown that medications are most effective when used in conjunction with other therapies.

MEDICATIONS USED IN THE TREATMENT OF SUBSTANCE USE DISORDERS					
Drug	**Dose Range**	**Typical Starting Dose**	**Potential Adverse Effects**	**Route(s)**	**DEA Schedule**
Opioid Use Disorder					
Buprenorphine/ naloxone (Bunavail, Suboxone, Zubsolv)	Buprenorphine: 0.7–24 mg/day Naloxone: 0.18–6 mg/day	4/1 mg/day	Pain, headache, nausea, diaphoresis	Buccal film, sublingual film, sublingual tablet	CIII
Methadone (Dolophine, Methadose, DISKETS)	20–120 mg/day	20–30 mg/day	Pruritus, constipation, cardiac abnormalities	PO, IV	CII
Naltrexone (Vivitrol)	PO: 25-50 mg/day IM: 380 mg/week	PO: 25 mg/day IM: 380 mg/week	Injection site reactions, anxiety, syncope	PO, IM	Not scheduled
Buprenorphine (Belbuca, Buprenex, Butrans, Probuphine, Sublocade)	SQ: 100–300 mg/month SL: 2–24 mg/day	SQ: 300 mg/month Implant: 4 implants SL: 2–4 mg/day	Few	Sublingual tablet, subdermal implant, SQ injection	CIII
Alcohol Use Disorder					
Acamprosate (Campral)	666 mg TID	666 mg TID	Diarrhea	PO	Not scheduled
Naltrexone (Vivitrol)	PO: 25–100 mg/day IM: 380 mg/month	PO: 50 mg/day IM: 380 mg/month	Injection site reactions, anxiety, syncope	PO, IM	Not scheduled
Disulfiram	125–500 mg/day	250 mg/day	Bitter taste, impotence, drowsiness	PO	Not scheduled
Tobacco Use Disorder					
Bupropion, sustained-release (Zyban)	150 mg daily or BID	150 mg/day	Weight loss, constipation, agitation, xerostomia, nausea	PO	Not scheduled
Nicotine	Gum: Up to a maximum 30 pieces/day Inhaler: 6–16 cartridges/day Lozenge: Titrate to 1 lozenge every 4 to 8 hours Nasal spray: Maximum 80 sprays/day Patch: One patch/day for 8 weeks	Gum: 1 to 2 pieces/hour (2 mg/piece) Inhaler: 6 cartridges/day Lozenge: One lozenge every 1 to 2 hours Nasal spray: 1 spray in each nostril once or twice per hour Patch: One patch/day	Oral irritation, headache, dyspepsia, nasal discomfort, cough, rhinitis	PO, intranasal, transdermal	Not scheduled
Varenicline (Chantix)	1 mg BID up to 12 weeks	0.5 mg/day	Nausea, abnormal dreams, headache	PO	Not scheduled

BID = two times per day, DEA = Drug Enforcement Administration, IM = intramuscular, IV = intravenous, PO = oral, SL = sublingual, SQ = subcutaneous, TID = three times per day.

Source: [39] *Table 2*

Disulfiram

Disulfiram, commonly known as Antabuse, was the first drug to be made available for the treatment of alcohol use disorder. It was approved for treatment of alcohol use disorder by the U.S. Food and Drug Administration (FDA) in 1951 and has been used safely and effectively for decades. It works by blocking an enzyme, aldehyde dehydrogenase, that helps metabolize alcohol. Taking even one drink while on disulfiram causes the alcohol at the acetaldehyde stage to accumulate in the blood. This produces nausea, vomiting, sweating, and even difficulty breathing. More alcohol in the patient's system produces more severe reactions (e.g., respiratory depression, cardiovascular collapse, unconsciousness, convulsions, death) [41; 42]. Patients must also be mindful of consuming even minute amounts of alcohol in foods, over-the-counter medications, mouthwash, and even topical lotions. Disulfiram can be effective for people who have completed alcohol withdrawal, are committed to staying sober, and are willing to take the medication under the supervision of a family member or treatment program [41]. Due to more modern and improved medication modalities, many clinicians prescribe disulfiram as a last-resort intervention. Although widely used, it is less clearly supported by clinical trial evidence [43; 44; 45].

The recommended dose for disulfiram is 250 mg/day, which can be increased to 500 mg based upon whether a patient experiences the disulfiram-ethanol reaction [46]. Doses may need to be reduced in patients older than 60 years of age [41]. Labeling for disulfiram includes several precautions regarding drug-drug interactions; therefore, caution should be used when prescribing it to older adults at risk for polypharmacy [41]. Due to the physiologic changes that occur with use, use of disulfiram is not recommended in patients with diabetes, cardiovascular or cerebrovascular disease, or kidney or liver failure. It also is contraindicated in the presence of psychoses and pregnancy and in those with high levels of impulsivity and suicidality [41].

Naltrexone

Naltrexone (ReVia) is an opioid antagonist that interferes with the rewarding or pleasurable effects of alcohol and reduces alcohol craving [47; 48; 49]. The exact mechanisms by which naltrexone induces the reduction in alcohol consumption observed in patients with alcohol use disorder is not entirely understood, but preclinical data suggest involvement of the endogenous opioid system [41]. Naltrexone has been shown to reduce alcohol relapses, decrease the likelihood that a slip becomes a relapse, and decrease the total amount of drinking [41]. The FDA approved the use of oral naltrexone in alcohol use disorder in December 1994 [41; 49]. In 2006, the FDA approved an extended-release injectable formulation, which is indicated for use only in patients who can refrain from drinking for several days prior to beginning treatment [41]. In 2010, the FDA approved the injectable naltrexone for the prevention of relapse to opioid dependence following opioid detoxification [41].

After a complete history, physical exam, and laboratory testing, most patients are started on 50 mg orally per day [39]. For most patients, this is the safe and effective dose of naltrexone. However, in a four-month study period, the COMBINE study demonstrated efficacy of naltrexone at a dose of 100 mg daily [50]. Some treatment providers give patients a naltrexone identification card or ask them to order a MedicAlert bracelet that clearly indicates that they are maintained on an opioid antagonist, so if they need an opiate drug or medication for pain relief, the dose of the pain medication can be adjusted higher. Meta-analyses have revealed that approximately 70% of previous clinical trials that measured reductions in "heavy or excessive drinking" demonstrated an advantage for prescribing naltrexone over placebo [51]. In another trial, naltrexone was determined to have the greatest impact on reducing daily drinking when craving for alcohol was highest [52]. The approved dose of the extended-release formulation is 380 mg IM once per month. Pretreatment with oral naltrexone is not required before induction onto extended-release injectable naltrexone [41].

The most common side effects of naltrexone are light-headedness, diarrhea, dizziness, and nausea. Pain or tenderness at the injection site is a side effect unique to the extended-release injectable formulation [41]. Most side effects tend to disappear quickly in most patients. Naltrexone is not recommended for patients with acute hepatitis or liver failure, for adolescents, or for pregnant or breastfeeding women [41; 50]. Weight loss and increased interest in sex have been reported by some patients. In general, patients maintained on opioid antagonists should be treated with nonopioid cough, antidiarrheal, headache, and pain medications. The patient's family or physician should call the treating physician if questions arise about opioid blockade or analgesia. It is important to realize that naltrexone is not disulfiram; drinking while maintained on naltrexone does not produce side effects or symptoms.

Naltrexone works best when it is used in the context of a full spectrum of treatment services, possibly including traditional 12-step fellowship-based treatments. Studies show also that naltrexone is effective when coupled with CBT. Patients receiving medical management with naltrexone, CBT, or both fared better on drinking outcomes [50].

Acamprosate

Acamprosate (Campral) is a synthetic compound that has a chemical structure similar to that of the naturally occurring amino acid neurotransmitters taurine and gamma-aminobutyric acid (GABA) [39]. Because chronic alcohol use is associated with decreased GABA and glutamate activity, a hyperexcitable glutamate system is one possible alcohol withdrawal mechanism. Glutamate systems may become unstable for 12 months after a person stops drinking. In a review of published, double-blind, placebo-controlled clinical trials evaluating the safety and efficacy of acamprosate in the treatment of alcohol use disorder, Mason reported that acamprosate appeared to improve treatment completion rate, abstinence rate and/or cumulative abstinence during treatment, and time to first drink, than placebo [53]. The effect on abstinence, combined with an excellent safety profile, lend support to the use of acamprosate across a broad range of patients with alcohol use disorder [54]. It is important to note that medication in combination with therapies can improve outcomes.

In July 2004, after many years of safe use in Europe and around the world, the FDA approved the use of acamprosate for the maintenance of alcohol abstinence [49]. As in the case of naltrexone, acamprosate reduces the reinforcing (pleasurable) effects of alcohol to reduce craving. Oral dosing is two 333-mg delayed-release tablets three times daily [39; 41]. Common side effects include diarrhea, anxiety, insomnia, nausea, dizziness, and weakness. Some research indicates that acamprosate may worsen depression and/or suicidal ideation; so, patients with a history of major depression should be monitored closely or prescribed a different medication [39]. Acamprosate is contraindicated in patients with severe renal impairment [39; 41]. Due to risk of diminished renal function in patients 65 years of age and older, baseline and frequent renal function tests should be performed in this population. Dose reductions also may be necessary [41].

Baclofen

Baclofen is a GABA agonist that may prove to be a unique therapeutic alternative to reduce alcohol craving and consumption. In a small, 12-week trial, patients with alcohol use disorder were given 10 mg of baclofen three times daily paired with motivational enhancement therapy. Patients experienced a reduction in number of drinks, drinking days, anxiety, and craving [55]. In a study of patients with alcohol use disorder and liver cirrhosis, baclofen was also found to work favorably in maintenance of alcohol abstinence. Seventy-one percent of baclofen-treated patients maintained abstinence as compared with 29% of the placebo group [56]. A 2018 meta-analysis of 12 randomized controlled trials that compared the efficacy of baclofen to placebo found that baclofen was associated with higher rates of abstinence than placebo but that its effects were not superior to placebo in increasing the number of abstinent days or in decreasing heavy drinking, craving, depression, or anxiety [57].

Anticonvulsants

Research has demonstrated that topiramate is efficacious in decreasing heavy drinking among individuals with alcohol use disorder [58]. In a controlled study, topiramate produced significant and meaningful improvement in a wide variety of drinking outcomes [59]. Topiramate may suppress the craving and rewarding effects of alcohol [60]. In a double-blind, controlled trial, 150 patients with alcohol use disorder were randomized to escalating doses of topiramate (25–300 mg/day) or placebo. Those on topiramate had a reduction in self-reported drinking (number of drinks and drinking days), alcohol craving, and plasma gamma-glutamyl transferase (an indicator of alcohol consumption) [61]. Side effects of topiramate include numbness in the extremities, fatigue, confusion, paresthesia, depression, change in taste, and weight loss. Use of topiramate for alcohol use disorder is off-label [39].

Carbamazepine has proven effective for treating acute alcohol withdrawal [62]. Its side effects include nausea, vomiting, drowsiness, dizziness, chest pain, headache, trouble urinating, numbness in extremities, liver damage, and allergic reaction [39]. In a 12-month, double-blind, placebo-controlled trial, 29 patients were assigned to carbamazepine three times daily (to reach an average blood level of 6 mg/liter) or placebo. Those treated with carbamazepine showed a delay in time to first drink and a decrease in number of drinks and drinking days [63].

Oxcarbazepine is a carbamazepine derivative, with fewer side effects and contraindications, used to prevent relapse in patients with alcohol use disorder by blocking alcohol withdrawal [62]. A group of 84 patients with alcohol use disorder following detoxification were randomized to 50 mg naltrexone, 1,500–1,800 mg oxcarbazepine, or 600–900 mg oxcarbazepine for 90 days. Approximately 58.6% of the high-dose oxcarbazepine patients remained alcohol-free, a significantly larger number as compared to the low-dose (42.8%) and naltrexone groups (40.7%) [64].

Opioid Use Disorder

Any treatment for opioid use disorder must take into consideration the chronic relapsing nature of opioid dependence, characterized by a variable course of relapse and remission in many patients. Treatments should emphasize patient motivation, psychoeducation, continuity of care, integration of pharmacotherapy and psychosocial support, and improved liaison between the treatment staff and the judicial system. Pharmacotherapy must be offered in a comprehensive healthcare context that also addresses the psychosocial aspects of dependence [65]. Patients with opioid use disorder frequently suffer from physical and psychiatric disorders, and targeted interventions of psychiatric comorbidity are essential in improving treatment outcome for these patients [65]. Polysubstance abuse is the rule rather than the exception in opioid use disorder, and concurrent use of other substances should be carefully monitored and treated when necessary [65]. Incarceration should never automatically result in discontinuation of an existing treatment; imprisonment offers a window of opportunity to initiate or restart treatment with a necessary continuation after release [65].

Crisis Intervention

Which drug is considered the criterion standard in reversing respiratory depression and coma in acute opioid overdose?

In response to acute overdose, the short-acting opioid antagonist naloxone is considered the criterion standard. Naloxone is effective in reversing respiratory depression and coma in patients who have overdosed. There is no evidence that subcutaneous or intramuscular use is inferior to intravenous naloxone. This prompted discussion of making naloxone available to the general public for administration outside the healthcare setting to treat acute opioid overdose, and in 2014, the FDA approved naloxone as an autoinjector dosage form for home use by family members or caregivers [66]. The autoinjector delivers 0.4 mg naloxone intramuscularly or subcutaneously. The autoinjector comes with visual and voice instruction, including directions to seek emergency medical care after use [66]. In 2015, the FDA approved intranasal naloxone after a fast-track designation and priority review. Intranasal naloxone is indicated for the emergency treatment of known or suspected opioid overdose, as manifested by respiratory and/or central nervous system depression. It is available in a ready-to-use 2-mg, 4-mg, or 8-mg single-dose sprayer [67; 68; 69]. In 2023, the FDA approved 4-mg nasal spray naloxone for over-the-counter use [173].

EVIDENCE-BASED PRACTICE RECOMMENDATION

According to the World Health Organization, people likely to witness an opioid overdose should have access to naloxone and be instructed in its administration to enable them to use it for the emergency management of suspected opioid overdose.

(https://www.who.int/publications/i/item/9789241548816. Last accessed April 27, 2023.)

Strength of Recommendation/Level of Evidence: Strong/very low

Harm Reduction

Harm reduction measures are primarily employed to minimize the morbidity and mortality from opioid abuse and to reduce public nuisance [2; 70]. As a part of this effort, measures to prevent and minimize the frequency and severity of overdoses have been identified. Enrollment in opioid substitution therapy, with agents such as methadone and buprenorphine, substantially reduces the risk of overdose as well as the risk for infection and other sequelae of illicit opioid use [2; 70].

Detoxification

The three primary treatment modalities used for detoxification are opioid agonists, non-opioid medications, and rapid and ultra-rapid opioid detoxification [71]. The most frequently employed method of opioid withdrawal is a slow, supervised detoxification during which an opioid agonist, usually methadone, is substituted for the abused opioid [72]. Methadone is the most frequently used opioid agonist due to the convenience of its once-a-day dosing [71]. Methadone is highly bound to plasma proteins and accumulates more readily than heroin in all body tissues. Methadone also has a longer half-life, approximately 22 hours, which makes withdrawal more difficult than from heroin. Substitution therapy with methadone has a high initial dropout rate (30% to 90%) and an early relapse rate. Alternative pharmacologic detoxification choices include clonidine (with or without methadone), midazolam, trazodone, or buprenorphine [72].

Many opioid withdrawal symptoms, such as restlessness, rhinorrhea, lacrimation, diaphoresis, myosis, piloerection, and cardiovascular changes, are mediated through increased sympathetic activation, the result of increased neuron activity in the locus coeruleus. Non-opioid agents (such as clonidine), which inhibit hyperactivation of noradrenergic pathways stemming from the locus coeruleus nucleus, have been used to manage acute withdrawal [72; 73]. The first non-opioid treatment approved for the management of opioid withdrawal symptoms is lofexidine [74]. In studies, patients treated with lofexidine reported less severe withdrawal symptoms and were more likely to complete treatment.

However, some withdrawal symptoms, including anxiety and myalgias, are resistant to clonidine; benzodiazepines and non-steroidal anti-inflammatory drugs (NSAIDs) may be necessary to treat these symptoms. To mitigate withdrawal symptoms and assist in detoxification, alpha2-agonists, opioid agonist-antagonists, benzodiazepines, and antidepressants have been used [72].

Agonist Replacement Therapy

The goal of opioid replacement therapy is to reduce illicit drug use and associated health risks, with secondary goals of reducing unsafe sexual practices, improving vocational and psychosocial functioning, and enhancing quality of life [71]. The theoretical basis of opioid replacement stems from the finding that chronic opioid use results in an endogenous opioid deficiency as a result of the down-regulation of opioid production. This creates overwhelming cravings and necessitates interventions that shift the dependent patient's attention and drive from obsessive preoccupation with the next use of opioids to more adaptive areas of focus, such as work, relationships, and non-drug leisure activities [71].

EVIDENCE-BASED PRACTICE RECOMMENDATION

For patients with opioid use disorder, the Department of Veterans Affairs Work Group recommends offering one of the following medications, considering patient preferences: buprenorphine/naloxone or methadone (in an opioid treatment program).

(https://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPG.pdf. Last accessed April 27, 2023.)

Strength of Recommendation: Strong for

Methadone is now the most inexpensive and empirically validated agent available for use in opioid replacement therapy. Studies have shown one-year treatment retention rates of 80%, with significant reductions in illicit opioid use [71].

Treatment is initiated with a dose of 25–30 mg and is gradually titrated in 5- to 10-mg increments per day to a desired range of 60–120 mg. Low-dose treatment is associated with less positive outcomes than doses of 60–120 mg/day or greater [71; 75]. One published review of efficacy literature concluded that high doses of methadone (>50 mg daily) are more effective than low doses (<50 mg daily) in reducing illicit opioid use. This may be due to the increased availability of highly pure heroin [75]. Additionally, high doses of methadone are more effective than low doses of buprenorphine (<8 mg daily). High dosages of methadone are comparable to high dosages of buprenorphine (>8 mg daily) on measures of treatment retention and reduction of illicit opioid use [65]. Methadone is contraindicated for the following patients [73]:

- Those with known hypersensitivity to methadone hydrochloride
- Those experiencing respiratory depression
- Those with acute bronchial asthma or hypercapnia
- Those with known or suspected paralytic ileus

EVIDENCE-BASED PRACTICE RECOMMENDATION

When considering initiation of methadone, the American Pain Society recommends that clinicians perform an individualized medical and behavioral risk evaluation to assess risks and benefits of methadone, given methadone's specific pharmacologic properties and adverse effect profile.

(https://www.jpain.org/article/S1526-5900(14)00522-7/fulltext. Last accessed April 27, 2023.)

Strength of Recommendation/Level of Evidence: Strong/low

Buprenorphine offers several advantages over methadone, including lower cost, milder withdrawal symptoms following abrupt cessation, lower risk of overdose, and longer duration of action, allowing alternate-day dosing [71; 76]. Identifying subpopulations of opioid addicts who differentially respond to buprenorphine versus methadone has not been clearly established. However, patients with less chronic and less severe heroin dependence benefit more fully from buprenorphine than from a pure opioid agonist like methadone [71].

The transition to buprenorphine from long-acting opioids is difficult [77]. The ASAM warns that diversion and misuse are possible with buprenorphine, as is physical dependence. Respiratory depression may occur if buprenorphine is used with central nervous system depressants including alcohol, other opioids, and illicit drugs. Neonatal withdrawal has also been reported after use of buprenorphine during pregnancy. Buprenorphine is not recommended for patients with severe hepatic impairment [73].

Higher doses of buprenorphine (12 mg or greater) are more effective than lower doses in reducing illicit opioid use, with some studies reporting similar efficacy to methadone on major treatment-outcome measures. The primary advantage of buprenorphine over methadone is its superior safety profile [77].

Slow-release formulations of morphine that are effective with once-daily dosing are a viable alternative in the treatment of opioid dependence. These formulations considerably delay time to peak concentration after oral administration, resulting in delayed onset of action and making the reinforcing effects very weak when it is administered orally. Several trials have suggested that slow-release morphine has approximately equal efficacy with methadone; however, there is no definitive evidence of this effect [77; 78; 79]. Slow-release oral morphine may be a viable alternative for patients who are intolerant to methadone [80].

Tobacco Use Disorder

The first-line pharmacologic interventions for smoking cessation are nicotine-replacement therapy (NRT), bupropion, and varenicline [81; 82]. However, no pharmacotherapy has been approved for use among pregnant or nursing women.

Bupropion

Bupropion is an atypical antidepressant that has both dopaminergic and adrenergic actions [83]. In 1998, the slow-release preparation of bupropion became available as a prescription item specifically for smoking cessation, with the trade name Zyban. This treatment could be appropriate for smokers who do not wish to use an NRT or for those whose treatment with NRT has failed. Unlike NRT, smokers begin bupropion treatment one week prior to cessation. The suggested dosage is 300 mg/day, and the duration of treatment is 7 to 12 weeks [84]. A double-blind, placebo-controlled trial randomized patients to placebo or sustained-released bupropion (50 mg twice a day, 150 mg once a day, or 150 mg twice a day) and treated them for six weeks. Smokers with active depression were excluded, though smokers with a history of depression were not. The cessation rates at the end of therapy were 10.5%, 13.7%, 18.3%, and 24.4%, respectively. Follow-up at one year suggested a continued benefit of bupropion therapy [85]. Data from a study of bupropion combined with transdermal nicotine showed high long-term quit rates with the combination therapy [86]. Discontinuation of treatment may be appropriate for individuals unable to achieve significant progress after seven weeks, as success after this point is unlikely [39].

Varenicline Tartrate

Another effective non-nicotine therapy for smoking cessation is varenicline tartrate, a partial agonist selective for nicotine acetylcholine receptor subtypes. Released in 2006, varenicline is available in monthly dose packs (0.5 mg and 1 mg tablets) and is approved for a 12-week course of treatment [82]. Patients able to quit smoking may continue the therapy for an additional

12 weeks for increased likelihood of long-term cessation and even up to a year in certain cases, to prevent relapse; however, medication should be stopped and patients should be reassessed if the intervention has not led to smoking cessation within the initial 12 week timeframe [39; 87; 88]. Clinical trials reveal that varenicline may be favorable to bupropion for abstinence (44% versus 30%); the medication has also been shown to help at least 20% of patients remain smoke-free for up to one year [89; 90]. Recognizing that cessation success rates increase when pharmacologic and behavioral therapies are combined, the manufacturer urges patients to combine use of varenicline with a behavioral support plan. Co-administration of varenicline and transdermal nicotine may exacerbate incidence of nausea, headache, vomiting, dizziness, dyspepsia, and fatigue. One study found varenicline alone to be more effective than other treatment options, while a meta-analysis study found that combination therapy (varenicline and NRT) was more effective than varenicline alone [91; 92]. In 2021, the manufacturer of Chantix, a brand of varenicline, halted production of varenicline due to unacceptably high levels of nitrosamines; however, this issue was considered resolved by May 2022 [93]. In addition, all lots of 0.5-mg and 1-mg tablets of Chantix were subject to a voluntary recall. However, the FDA does not recommend that patients halt use of varenicline, and generic formulations and other brands remained available.

Other Options

The two second-line drugs for smoking cessation are clonidine and nortriptyline [81]. Clonidine is an antihypertensive medication that is administered orally or transdermally. It appears to increase the smoking cessation rate by approximately 11%; however, clonidine is known to produce such side effects as dry mouth, dizziness, sedation, and orthostatic hypotension [39; 94]. Clonidine has not been approved by the FDA for smoking cessation but has been used with individuals who have failed NRT or bupropion [39]. Nortriptyline is a tricyclic antidepressant that has been used to assist smoking cessation, although this is an unlabeled use [39]. A 12% improvement in cessation over controls has been reported, but the limited number of trials, combined with the adverse side effects (e.g., dry mouth, weight gain, constipation, drowsiness, sexual problems), makes nortriptyline a second-line intervention [81]. Several controlled trials have failed to show any benefit for either agent [39].

POLYSUBSTANCE USE

Despite the increased prevalence of individuals using multiple substances at the same time, limited research exists on evidence-based treatment practices that have demonstrated improved outcomes for individuals who use more than one substance [95]. Therefore, there is a need to identify and assess the effectiveness of treatment practices so that clinicians and organizations have the necessary resources and evidence-based practices to assist this population.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has identified three evidence-based practices that engage and improve outcomes for individuals with concurrent substance use and concurrent substance use disorders [95]:

- FDA-approved pharmacotherapy together with counseling to treat:
  - Alcohol and cocaine dependence
  - Cocaine and opioid dependence
- Contingency management together with FDA-approved pharmacotherapy and counseling to treat:
  - Cocaine and opioid use and dependence
  - Cocaine dependence and alcohol and opioid use
- Twelve-step facilitation therapy together with FDA-approved pharmacotherapy and counseling to treat:
  - Cocaine and opioid dependence
  - Opioid and other substance dependence

CO-OCCURRING MENTAL DISORDERS

In the United States, 7.7 million adults have co-occurring mental and substance use disorders. Of the 20.3 million adults with substance use disorders, 37.9% also had mental illnesses. Among the 42.1 million adults with mental illness, 18.2% also had substance use disorders [96]. No specific combinations of mental and substance use disorders are defined uniquely as co-occurring disorders, but the most common mental disorders seen in substance use disorder treatment include [96]:

- Anxiety and mood disorders
- Schizophrenia
- Bipolar disorder
- Major depressive disorder
- Conduct disorders
- Post-traumatic stress disorder
- Attention deficit hyperactivity disorder (ADHD)

Patients with comorbid disorders demonstrate poorer treatment adherence and higher rates of treatment dropout than those without mental illness, which negatively affects outcomes [97]. Integrated treatment for comorbid drug use disorder and mental illness has been found to be consistently superior compared with separate treatment of each diagnosis. Integrated treatment of co-occurring disorders often involves using CBT strategies to boost interpersonal and coping skills and using approaches that support motivation and functional recovery.

Assessment

It is important to assess patients with substance use disorder for other psychiatric and substance use disorders. For example, alcohol and cocaine use disorders are frequent comorbidities in patients with opioid use disorder and can aggravate depressive symptoms [73; 99]. Bipolar illness is rare but has substantial treatment implications. Anxiety disorders frequently co-occur with depression, and traumatic experiences and post-traumatic stress disorder are common and should be thoroughly evaluated and treated [98; 99]. Independent disorders are psychiatric conditions occurring during periods of sustained abstinence or having an onset before the substance use disorder. A positive family history can aid in identifying an independent psychiatric disorder.

Comprehensive assessment tools can reduce the chance of a missed or incorrect diagnosis. Patients with psychiatric comorbidities often exhibit symptoms that are more persistent, severe, and resistant to treatment compared to patients who have either disorder alone [100; 101; 102; 103]. Assessment is critical to identify concomitant medical and psychiatric conditions that may need immediate attention and require transfer to a higher level of care [73]. The ASAM recommends that clinicians also assess social and environmental factors to identify facilitators and barriers to treatment, specifically to pharmacotherapy [73].

Treatment Approach

What should be the initial focus of treatment of comorbid mental and substance use disorders?

Treatment should initially focus on stabilization of the patient's substance use disorder, with an initial goal of two to four weeks abstinence before addressing comorbidities. Patients who persistently display symptoms of a psychiatric disorder during abstinence should be considered as having an independent disorder and should receive prompt psychiatric treatment [104].

Although depressive symptoms often improve following treatment admission, significant symptoms will persist in some patients [98]. Antidepressant medications can be effective in patients dually diagnosed with substance use disorder and depression when used at adequate doses for at least six weeks [105]. Factors emphasizing prompt antidepressant treatment include greater severity of depression, suicide risk, and co-occurring anxiety disorders [98].

Selective serotonin reuptake inhibitors (SSRIs) are generally safe and well-tolerated, but clinical trials with these agents in methadone patients have been negative [98]. Therefore, SSRIs may be considered first-line treatment based on their safety profile, but if the patient does not respond, then tricyclic antidepressants or newer generation agents should be considered. SSRIs in combination with CBT have been found to be highly effective for treating clients with comorbid depression [106]. More stimulating antidepressants, such as venlafaxine and bupropion, may be suitable in patients with prominent low energy or past or current symptoms consistent with ADHD [98].

The utility of nonpharmacologic treatments should be emphasized. Psychosocial therapies are as effective as pharmacotherapy in the treatment of mild-to-moderate depressive and anxiety symptoms. Treatment of personality disorders is nonpharmacologic [104]. If depression persists, psychosocial modalities, such as CBT, supportive therapy, or contingency management, have some evidence to support their efficacy in patients with substance use disorders [98; 106].

FACTORS IMPACTING RECOVERY

Stigma

Although substance use disorders affect millions of persons in the United States every year, stigma and shame surrounding these disorders remains. Although it is clear that substance use disorders are complex mental disorders, many continue to view it as a result of moral weakness and flawed character [107]. Experiences of this stigma, especially if expressed by a healthcare professional, can impede patients from seeking help or adhering to treatment.

Trauma

Various studies have found a disproportionately higher number of abuse, neglect, or trauma histories in patients with substance use disorders than in the general population [108; 109; 110; 111; 112]. Furthermore, substance abuse increases the likelihood of victimization, which can further promulgate the cycle of coping with trauma-related stress and self-medicating with addictive substances [113; 114; 115; 116; 117].

Some experts have asserted that traditional models of addiction recovery and relapse prevention do not consider the significant role that unresolved trauma can play in an addicted individual's attempt at recovery [118]. It is possible that traditional approaches tend to marginalize women more than their male counterparts and fail to sufficiently address the role that trauma has played in the development and maintenance of substance use disorder. An integrated, more holistic approach is needed to promote long-term recovery and prevent relapse [119].

Social Determinants of Health

Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. They can have a major impact on substance use disorder treatment and recovery. Examples of social determinants of health include [120]:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

Social determinants of health also contribute to wide health disparities and inequities. For example, people who lack reliable transportation are less likely to attend follow-up appointments or 12-step meetings, which raises the risk of relapse and treatment nonadherence [120].

LEGAL AND ETHICAL ISSUES IN THE TREATMENT OF SUBSTANCE USE DISORDERS

Which ethical issue should be considered when caring for patients with substance use disorders?

Federal statutes, regulations, and guidelines govern medications for opioid addiction. The SAMHSA's Division of Pharmacologic Therapies, part of SAMHSA's Center for Substance Abuse Treatment, manages the day-to-day oversight activities required to implement federal regulations surrounding the use medications approved by the FDA, such as methadone and buprenorphine for the treatment of opioid use disorder for practitioners and opioid treatment programs [121]. Some medications used to treat substance use disorder are controlled substances governed by the Controlled Substances Act.

Section 1262 of the Consolidated Appropriations Act of 2023 (also known as Omnibus bill), removes the federal requirement for practitioners to submit a Notice of Intent (i.e., have a DATA or X-waiver) to prescribe medications, like buprenorphine, for the treatment of opioid use disorder. All practitioners who have a current Drug Enforcement Administration (DEA) registration that includes Schedule III authority may now prescribe buprenorphine for opioid use disorder in their practice if permitted by applicable state law. This section also removes other federal requirements associated with the waiver, such as discipline restrictions, patient limits, and certification related to provision of counseling. Separately, section 1263 of the Consolidated Appropriations Act requires new or renewing DEA registrants, starting June 27, 2023, upon submission of their application, to have at least one of the following [122]:

- A total of eight hours of training from certain organizations on opioid or other substance use disorders for practitioners renewing or newly applying for a registration from the DEA to prescribe any Schedule II-V controlled medications
- Board certification in addiction medicine or addiction psychiatry from the American Board of Medical Specialties, American Board of Addiction Medicine, or the American Osteopathic Association
- Graduation within five years and status in good standing from medical, dental medicine, advanced practice nursing, or physician assistant school in the United States that included successful completion of an opioid or other substance use disorder curriculum of at least eight hours
- For dentists, the training may also include the safe pharmacologic management of dental pain and screening, brief intervention, and referral for appropriate treatment of patients with or at risk of developing opioid and other substance use disorders

Key ethical issues to consider when caring for patients with substance use disorders include informed consent, confidentiality, autonomy, competence, access to services, and explicit and implicit bias.

PAIN MANAGEMENT AND SUBSTANCE MISUSE

Persistent pain has been reported to affect one in three adults in the United States [123]. As such, a significant portion of persons with substance use disorders will have comorbid and sometimes chronic pain. There is no adequately validated instrument to differentiate pain patients who are at risk of dependence from those who are not. Research suggests that patients, even those with alcohol use disorder, with no history of opioid dependence are not at heightened risk of becoming addicted with short-term opioid exposure. However, those with a positive history of dependence would benefit from active recovery efforts while receiving such medications.

Despite the rise in prescription opioid analgesic use and misuse, definitive data on the rate of dependence among patients administered opioids for acute pain does not yet exist. There is, however, agreement on how to minimize the risk of iatrogenic dependence. These steps include screening for risk potential based on a family history of substance abuse and the exploration of different delivery systems that adequately treat pain but minimize abuse potential. Although a pattern of aberrant behavior may be grounds for caution, a history of opioid misuse does not necessarily preclude a patient from successful treatment with an opioid. Screening for psychologic disorders is also advisable, including psychosomatic causes of pain.

PAIN MANAGEMENT APPROACHES

Healthcare professionals should know the best clinical practices in opioid prescribing, including the associated risks of opioids, approaches to the assessment of pain and function, and pain management modalities. Pharmacologic and nonpharmacologic approaches should be used on the basis of current knowledge in the evidence base or best clinical practices. Patients with moderate-to-severe chronic pain who have been assessed and treated, over a period of time, with non-opioid therapy or nonpharmacologic pain therapy without adequate pain relief, are considered to be candidates for a trial of opioid therapy [124; 125; 127]. Initial treatment should always be considered individually determined and as a trial of therapy, not a definitive course of treatment [126].

The Centers for Disease Control and Prevention (CDC) originally published *Guideline for Prescribing Opioids for Chronic Pain—United States, 2016* in an effort to address an ongoing crisis of prescription opioid misuse, abuse, and overdose [125]. While these guidelines were based on the best available evidence at the time, there was some criticism that they were too focused on limiting opioid prescriptions—to the point of patients and prescribers complaining of stigma and reduced access to needed opioid analgesics. In response to this and to the availability of new evidence, the CDC published updates to the guideline in 2022 [127]. The updated clinical practice guideline is intended to achieve improved communication between clinicians and patients about the risks and benefits of pain treatment, including opioid therapy for pain; improved safety and effectiveness for pain treatment, resulting in improved function and quality of life for patients experiencing pain; and a reduction in the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death [127].

The 2022 clinical practice guideline includes 12 recommendations for clinicians who are prescribing opioids for outpatients 18 years of age or older with acute (duration <1 month) pain, subacute (duration of 1 to 3 months) pain, or chronic (duration of >3 months) pain outside of sickle cell disease related pain management, cancer pain treatment, palliative care, and end-of-life care. These recommendations are graded according to applicability and strength of the supporting evidence [127].

Acute Pain

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids in a quantity no greater than that needed for the expected duration of severe pain. In most cases, three days or less will be sufficient; more than seven days will rarely be needed [125; 127]. However, it may be necessary to prescribe for longer periods in patients with acute severe pain. Approximately half of all states have passed legislation limiting initial opioid prescriptions for acute pain to a seven-day supply or less, and many insurers, pharmacy benefit managers, and pharmacies have enacted similar policies [127].

With postoperative, acute, or intermittent pain, analgesia often requires frequent titration, and the two- to four-hour analgesic duration with short-acting hydrocodone, morphine, and oxycodone is more effective than extended-release formulations. Short-acting opioids are also recommended in patients who are medically unstable or with highly variable pain intensity [128; 129; 130].

Chronic Pain

Nonpharmacologic therapy and non-opioid pharmacologic therapy are the preferred first-line therapies for chronic pain. Several nonpharmacologic approaches are therapeutic complements to pain-relieving medication, lessening the need for higher doses and perhaps minimizing side effects. These interventions can help decrease pain or distress that may be contributing to the pain sensation. Approaches include palliative radiotherapy, complementary/alternative methods, manipulative and body-based methods, and cognitive/behavioral techniques. The choice of a specific nonpharmacologic intervention is based on the patient's preference, which, in turn, is usually based on a successful experience in the past.

Implantable intrathecal opioid infusion and/or spinal cord stimulation may be options for severe, intractable pain. Both options require that devices or ports be implanted, with associated risks. With intrathecal opioid infusion, the ability to deliver the drug directly into the spine provides pain relief with significantly smaller opioid doses, which can help to minimize side effects (e.g., drowsiness, dizziness, dry mouth, nausea, vomiting, and constipation) that can accompany systemic pain medications that might be delivered orally, transdermally, or through an IV [131]. However, use of opioid infusion has traditionally been limited to cancer pain. With spinal cord stimulation therapy, the most challenging aspect is patient selection. In order for patients to be considered for spinal cord stimulation, other options should have been ineffective or be contraindicated. Spinal cord stimulation is indicated for severe neuropathic pain persisting at least six months.

If opioids are used, they should be combined with nonpharmacologic therapy and non-opioid pharmacologic therapy, as appropriate. Clinicians should consider opioid therapy only if expected benefits for pain and function are anticipated to outweigh risks to the patient [125; 127].

Opioid therapy for chronic pain should be presented as a trial for a pre-defined period (e.g., ≤30 days). The goals of treatment should be established with all patients prior to the initiation of opioid therapy, including reasonable improvements in pain, function, depression, anxiety, and avoidance of unnecessary or excessive medication use [125; 127; 132]. The treatment plan should describe therapy selection, measures of progress, and other diagnostic evaluations, consultations, referrals, and therapies.

In patients who are opioid-naïve, start at the lowest possible dose and titrate to effect. Dosages for patients who are opioid-tolerant should always be individualized and titrated by efficacy and tolerability [125; 127; 132]. When starting opioid therapy for chronic pain, clinicians should prescribe short-acting instead of extended-release/long-acting opioid formulations [125; 127].

The need for frequent progress and benefit/risk assessments during the trial should be included in patient education. Patients should also have full knowledge of the warning signs and symptoms of respiratory depression. Prescribers should carefully reassess evidence of benefits and risks when increasing the dosage to ≥50 mg morphine milligram equivalents (MME) per day. In its 2016 guideline, the CDC recommended that decisions to titrate dosage to ≥90 mg MME/day should be avoided or carefully justified [125; 133]. This recommendation does not appear in the 2022 revision [127].

Prescribers should be knowledgeable of federal and state opioid prescribing regulations. Issues of equianalgesic dosing, close patient monitoring during all dose changes, and cross-tolerance with opioid conversion should be considered. If necessary, treatment may be augmented, with preference for nonopioid and immediate-release opioids over long-acting/extended-release opioids. Taper opioid dose when no longer needed [134].

Palliative Care and Pain at the End of Life

Unrelieved pain is the greatest fear among people with a life-limiting disease, and the need for an increased understanding of effective pain management is well-documented [135]. Although experts have noted that 75% to 90% of end-of-life pain can be managed effectively, rates of pain are high, even among people receiving palliative care [135; 136; 137; 138].

The inadequate management of pain is the result of several factors related to both patients and clinicians. In a survey of oncologists, patient reluctance to take opioids or to report pain were two of the most important barriers to effective pain relief [139]. This reluctance is related to a variety of attitudes and beliefs [135; 139]:

- Fear of addiction to opioids
- Worry that if pain is treated early, there will be no options for treatment of future pain
- Anxiety about unpleasant side effects from pain medications
- Fear that increasing pain means that the disease is getting worse
- Desire to be a "good" patient
- Concern about the high cost of medications

Education and open communication are the keys to overcoming these barriers. Every member of the healthcare team should reinforce accurate information about pain management with patients and families. The clinician should initiate conversations about pain management, especially regarding the use of opioids, as few patients will raise the issue themselves or even express their concerns unless they are specifically asked [140]. It is important to acknowledge patients' fears individually and provide information to help them differentiate fact from fiction. For example, when discussing opioids with a patient who fears addiction, the clinician should explain that the risk of addiction is low [135]. It is also helpful to note the difference between addiction and physical dependence.

There are several other ways clinicians can allay patients' fears about pain medication:

- Assure patients that the availability of pain relievers cannot be exhausted; there will always be medications if pain becomes more severe.
- Acknowledge that side effects may occur but emphasize that they can be managed promptly and safely and that some side effects will abate over time.
- Explain that pain and severity of disease are not necessarily related.

Encouraging patients to be honest about pain and other symptoms is also vital. Clinicians should ensure that patients understand that pain is multidimensional and emphasize the importance of talking to a member of the healthcare team about possible causes of pain, such as emotional or spiritual distress. The healthcare team and patient should explore psychosocial and cultural factors that may affect self-reporting of pain, such as concern about the cost of medication.

Clinicians' attitudes, beliefs, and experiences also influence pain management, with addiction, tolerance, side effects, and regulations being the most important concerns [135; 137; 139; 141]. A lack of appropriate education and training in the assessment and management of pain has been noted to be a substantial contributor to ineffective pain management [139; 141]. As a result, many clinicians, especially primary care physicians, do not feel confident about their ability to manage pain in their patients [139; 141].

Clinicians require a clear understanding of available medications to relieve pain, including appropriate dosing, safety profiles, and side effects. If necessary, clinicians should consult with pain specialists to develop an effective approach.

Strong opioids are used for severe pain at the end of life [136; 137]. Morphine, buprenorphine, oxycodone, hydromorphone, fentanyl, and methadone are the most widely used in the United States [142]. Unlike nonopioids, opioids do not have a ceiling effect, and the dose can be titrated until pain is relieved or side effects become unmanageable. Patients who are opioid-naïve or who have been receiving low doses of a weak opioid, the initial dose should be low, and, if pain persists, the dose may be titrated up daily until pain is controlled.

More than one route of opioid administration will be needed by many patients during end-of-life care, but in general, opioids should be given orally, as this route is the most convenient and least expensive. The transdermal route is preferred to the parenteral route, although dosing with a transdermal patch is less flexible and so may not be appropriate for patients with unstable pain [137]. Intramuscular injections should be avoided because injections are painful, drug absorption is unreliable, and the time to peak concentration is long [137].

CREATING A TREATMENT PLAN AND ASSESSMENT OF ADDICTION RISK

Information obtained by patient history, physical examination, and interview, from family members, a spouse, or state prescription drug monitoring program (PDMP), and from the use of screening and assessment tools can help the clinician to stratify the patient according to level of risk for developing problematic opioid behavioral responses (***Table 3***) [143; 144]. Low-risk patients receive the standard level of monitoring, vigilance, and care. Moderate-risk patients should be considered for an additional level of monitoring and provider contact, and high-risk patients are likely to require intensive and structured monitoring and follow-up contact, additional consultation with psychiatric and addiction medicine specialists, and limited supplies of short-acting opioid formulations [125; 127; 145].

RISK STRATIFICATION FOR PATIENTS PRESCRIBED OPIOIDS
Low Risk
Definable physical pathology with objective signs and reliable symptoms
Clinical correlation with diagnostic testing, including MRI, physical examination, and interventional diagnostic techniques
With or without mild psychologic comorbidity
With or without minor medical comorbidity
No or well-defined and controlled personal or family history of alcoholism or substance abuse
Age 45 years or older
High levels of pain acceptance and active coping strategies
High motivation and willingness to participate in multimodal therapy and attempting to function at normal levels
Medium Risk
Significant pain problems with objective signs and symptoms confirmed by radiologic evaluation, physical examination, or diagnostic interventions
Moderate psychologic problems, well controlled by therapy
Moderate coexisting medical disorders that are well controlled by medical therapy and are not affected by chronic opioid therapy (e.g., central sleep apnea)
Develops mild tolerance but not hyperalgesia without physical dependence or addiction
History of personal or family history of alcoholism or substance abuse
Pain involving more than three regions of the body
Defined pathology with moderate levels of pain acceptance and coping strategies
Willing to participate in multimodal therapy, attempting to function in normal daily life
High Risk
Widespread pain without objective signs and symptoms
Pain involving more than three regions of the body
Aberrant drug-related behavior
History of alcoholism or drug misuse, abuse, addiction, diversion, dependency, tolerance, or hyperalgesia
Major psychologic disorders
Age younger than 45 years
HIV-related pain
High levels of pain exacerbation and low levels of coping strategies
Unwilling to participate in multimodal therapy, not functioning close to a near normal lifestyle
HIV = human immunodeficiency syndrome, MRI = magnetic resonance imaging.

Source: [143; 144] *Table 3*

Before deciding to prescribe an opioid analgesic, clinicians should perform and document a detailed patient assessment that includes [132]:

- Pain indications for opioid therapy
- Nature and intensity of pain
- Past and current pain treatments and patient response
- Comorbid conditions
- Pain impact on physical and psychologic function
- Social support, housing, and employment
- Home environment (i.e., stressful or supportive)
- Pain impact on sleep, mood, work, relationships, leisure, and substance use
- Patient history of physical, emotional, or sexual abuse

If substance abuse is active, in remission, or in the patient's history, consult an addiction specialist before starting opioids [132]. In active substance abuse, do not prescribe opioids until the patient is engaged in treatment/recovery program or other arrangement made, such as addiction professional co-management and additional monitoring. When considering an opioid analgesic (particularly those that are extended-release or long-acting), one must always weigh the benefits against the risks of overdose, abuse, addiction, physical dependence and tolerance, adverse drug interactions, and accidental exposure by children [125; 127; 134].

Screening and assessment tools can help guide patient stratification according to risk level and inform the appropriate degree of structure and monitoring in the treatment plan. It should be noted that despite widespread endorsement of screening tools used to help determine patient risk level, most tools have not been extensively evaluated, validated, or compared to each other, and evidence of their reliability is poor [143; 144].

Risk Assessment Tools

Opioid Risk Tool (ORT)

The Opioid Risk Tool (ORT) is a five-item, patient-administered assessment to help predict aberrant drug-related behavior. The ORT is also used to establish patient risk level through categorization into low, medium, or high levels of risk for aberrant drug-related behaviors based on responses to questions of previous alcohol/drug abuse, psychologic disorders, and other risk factors [146].

Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R)

The Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R) is a patient-administered, 24-item screen with questions addressing history of alcohol/substance use, psychologic status, mood, cravings, and stress. Like the ORT, the SOAPP-R helps assess risk level of aberrant drug-related behaviors and the appropriate extent of monitoring [146; 147].

Screening Instrument or Substance Abuse Potential (SISAP)

The Screening Instrument or Substance Abuse Potential (SISAP) tool is a self-administered, five-item questionnaire addressing history developed used to predict the risk of opioid misuse. The SISAP is used to identify patients with a history of alcohol/substance abuse and improve pain management by facilitating focus on the appropriate use of opioid analgesics and therapeutic outcomes in the majority of patients who are not at risk of opioid abuse, while carefully monitoring those who may be at greater risk [146].

CAGE and CAGE-AID

What does the CAGE acronym stand for?

The original CAGE (Cut down, Annoyed, Guilty, and Eye-opener) Questionnaire consisted of four questions designed to help clinicians determine the likelihood that a patient was misusing or abusing alcohol. These same four questions were modified to create the CAGE-AID (adapted to include drugs), revised to assess the likelihood of current substance abuse [148].

Diagnosis, Intractability, Risk, and Efficacy (DIRE) Score

The Diagnosis, Intractability, Risk, and Efficacy (DIRE) risk assessment score is a clinician-rated questionnaire that is used to predict patient compliance with long-term opioid therapy [146; 149]. Patients scoring lower on the DIRE tool are poor candidates for long-term opioid analgesia.

Considerations for Pain Management in Patients with Comorbid Opioid Use Disorder

Although identification of an opioid use disorder can alter the expected benefits and risks of opioid therapy for pain, patients with co-occurring pain and substance use disorder require ongoing pain management that maximizes benefits relative to risks. Clinicians should use nonpharmacologic and nonopioid pharmacologic pain treatments as appropriate to provide optimal pain management [150]. For patients with pain who have an active opioid use disorder but are not in treatment, clinicians should consider buprenorphine or methadone treatment for opioid use disorder, which can also help with concurrent management of pain [150]. For patients who are treated with buprenorphine for opioid use disorder and experience acute pain, clinicians can consider temporarily increasing the buprenorphine dosing frequency (e.g., to twice a day) to help manage pain, given the duration of effects of buprenorphine is shorter for pain than for suppression of withdrawal [150; 151]. For severe acute pain (e.g., from trauma or unplanned major surgery) in patients receiving buprenorphine for opioid use disorder, clinicians can consider additional as-needed doses of buprenorphine. In supervised settings, adding a short-acting full agonist opioid to the patient's regular dosage of buprenorphine can be considered without discontinuing the patient's regular buprenorphine dosage; however, if a decision is made to discontinue buprenorphine to allow for more mu-opioid receptor availability, patients should be monitored closely because high doses of a full agonist opioid might be required, potentially leading to oversedation and respiratory depression as buprenorphine's partial agonist effect lessens. For patients receiving naltrexone for opioid use disorder, short-term use of higher-potency nonopioid analgesics (e.g., NSAIDs) can be considered to manage severe acute pain. Patients receiving methadone for opioid use disorder who require additional opioids as treatment for severe acute pain management should be carefully monitored, and when feasible should optimally be treated by a clinician experienced in the treatment of pain in consultation with their opioid treatment program [150]. The *ASAM National Practice Guideline for the Treatment of Opioid Use Disorder (2020 Focused Update)* provides additional recommendations for the management of patients receiving medications for opioid use disorder who have planned surgeries for which nonopioid therapies are not anticipated to provide sufficient pain relief [150].

Informed Consent and Treatment Agreements

The initial opioid prescription is preceded by a written informed consent or "treatment agreement" [132]. This agreement should address potential side effects, tolerance and/or physical dependence, drug interactions, motor skill impairment, limited evidence of long-term benefit, misuse, dependence, addiction, and overdose. Informed consent documents should include information regarding the risk/benefit profile for the drug(s) being prescribed. The prescribing policies should be clearly delineated, including the number/frequency of refills, early refills, and procedures for lost or stolen medications.

The treatment agreement also outlines joint physician and patient responsibilities. The patient agrees to using medications safely, refraining from "doctor shopping," and consenting to routine urine drug testing (UDT). The prescriber's responsibility is to address unforeseen problems and prescribe scheduled refills. Reasons for opioid therapy change or discontinuation should be listed. Agreements can also include sections related to follow-up visits, monitoring, and safe storage and disposal of unused drugs.

Periodic Review and Monitoring

When implementing a chronic pain treatment plan that involves the use of opioids, the patient should be frequently reassessed for changes in pain origin, health, and function [132]. This can include input from family members and/or the state PDMP. During the initiation phase and during any changes to the dosage or agent used, patient contact should be increased. At every visit, chronic opioid response may be monitored according to the "5 A's" [132; 152]:

- Analgesia
- Activities of daily living
- Adverse or side effects
- Aberrant drug-related behaviors
- Affect (i.e., patient mood)

Signs and symptoms that, if present, may suggest a problematic response to the opioid and interference with the goal of functional improvement include [153; 154]:

- Excessive sleeping or days and nights turned around
- Diminished appetite
- Short attention span or inability to concentrate
- Mood volatility, especially irritability
- Lack of involvement with others
- Impaired functioning due to drug effects
- Use of the opioid to regress instead of re-engaging in life
- Lack of attention to hygiene and appearance

The decision to continue, change, or terminate opioid therapy is based on progress toward treatment objectives and absence of adverse effects and risks of overdose or diversion [132]. Satisfactory therapy is indicated by improvements in pain, function, and quality of life. Brief assessment tools to assess pain and function may be useful, as may UDTs. Treatment plans may include periodic pill counts to confirm adherence and minimize diversion.

Involvement of Family

Family members of the patient can provide the clinician with valuable information that better informs decision making regarding continuing opioid therapy. Family members can observe whether a patient is losing control of his or her life or becoming less functional or more depressed during the course of opioid therapy. They can also provide input regarding positive or negative changes in patient function, attitude, and level of comfort. The following questions can be asked of family members or a spouse to help clarify whether the patient's response to opioid therapy is favorable or unfavorable [153; 154]:

- Is the person's day centered around taking the opioid medication? Response can help clarify long-term risks and benefits of the medication and identify other treatment options.
- Does the person take pain medication only on occasion, perhaps three or four times per week? If yes, the likelihood of addiction is low.
- Have there been any other substance (alcohol or drug) abuse problems in the person's life? An affirmative response should be taken into consideration when prescribing.
- Does the person in pain spend most of the day resting, avoiding activity, or feeling depressed? If so, this suggests the pain medication is failing to promote rehabilitation. Daily activity is essential, and the patient may be considered for enrollment in a graduated exercise program.
- Is the person in pain able to function (e.g., work, do household chores, play) with pain medication in a way that is clearly better than without? If yes, this suggests the pain medication is contributing to wellness.

Assessment Tools

VIGIL is the acronym for a five-step risk management strategy designed to empower clinicians to appropriately prescribe opioids for pain by reducing regulatory concerns and to give pharmacists a framework for resolving ambiguous opioid analgesic prescriptions in a manner that preserves legitimate patient need while potentially deterring diverters. The components of VIGIL are:

- Verification: Is this a responsible opioid user?
- Identification: Is the identity of this patient verifiable?

PATIENT RISK LEVEL AND FREQUENCY OF MONITORING			
Monitoring Tool	**Patient Risk Level**		
	Low	**Medium**	**High**
Urine drug test	Every 1 to 2 years	Every 6 to 12 months	Every 3 to 6 months
State prescription drug monitoring program	Twice per year	Three times per year	Four times per year

Source: [158] *Table 4*

- Generalization: Do we agree on mutual responsibilities and expectations?
- Interpretation: Do I feel comfortable allowing this person to have controlled substances?
- Legalization: Am I acting legally and responsibly?

The foundation of VIGIL is a collaborative physician/pharmacist relationship [155].

The Current Opioid Misuse Measure (COMM) is a 17-item patient self-report assessment designed to help clinicians identify misuse or abuse in patients being treated for chronic pain. Unlike the ORT and the SOAPP-R, the COMM identifies aberrant behaviors associated with opioid misuse in patients already receiving long-term opioid therapy [145]. Sample questions include: In the past 30 days, how often have you had to take more of your medication than prescribed? In the past 30 days, how much of your time was spent thinking about opioid medications (e.g., having enough, taking them, dosing schedule)?

Guidelines by the CDC, the Federation of State Medical Boards (FSMB), and the Joint Commission stress the importance of documentation from both a healthcare quality and medicolegal perspective. Research has found widespread deficits in chart notes and progress documentation with patients with chronic pain receiving opioid therapy, and the Pain Assessment and Documentation Tool (PADT) was designed to address these shortcomings [156]. The PADT is a clinician-directed interview, with most sections (e.g., analgesia, activities of daily living, adverse events) consisting of questions asked of the patient. However, the potential aberrant drug-related behavior section must be completed by the physician based on his or her observations of the patient.

The Brief Intervention Tool is a 26-item, "yes-no," patient-administered questionnaire used to identify early signs of opioid abuse or addiction. The items assess the extent of problems related to drug use in several areas, including drug use-related functional impairment [157].

Urine Drug Tests

UDTs may be used to monitor adherence to the prescribed treatment plan and to detect unsanctioned drug use. They should be used more often in patients receiving addiction therapy, but clinical judgment is the ultimate guide to testing frequency (***Table 4***) [158]. The CDC recommends clinicians should use UDT before starting opioid therapy and consider UDT at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs [125; 127]. However, this recommendation was based on low-quality evidence that indicates little confidence in the effect estimate.

Initially, testing involves the use of class-specific immunoassay drug panels [132]. If necessary, this may be followed with gas chromatography/mass spectrometry for specific drug or metabolite detection. It is important that testing identifies the specific drug rather than the drug class, and the prescribed opioid should be included in the screen. Any abnormalities should be confirmed with a laboratory toxicologist or clinical pathologist. Immunoassay may be used point-of-care for "on-the-spot" therapy changes, but the high error rate prevents its use in major clinical decisions except with liquid chromatography coupled to tandem mass spectrometry confirmation.

Urine test results suggesting opioid misuse should be discussed with the patient using a positive, supportive approach. The test results and the patient discussion should be documented.

Concurrent Use of Benzodiazepines

In 2019, 16% of persons who died of an opioid overdose also tested positive for benzodiazepines, a class of sedative medication commonly prescribed for anxiety, insomnia, panic attack, and muscle spasm [159]. Benzodiazepines work by raising the level of GABA in the brain. Common formulations include diazepam, alprazolam, and clonazepam. Combining benzodiazepines with opioids is unsafe because both classes of drug cause central nervous system depression and sedation and can decrease respiratory drive—the usual cause of overdose fatality. Both classes have the potential for drug dependence and addiction.

The CDC recommends that healthcare providers use particular caution prescribing benzodiazepines concurrently with opioids [125; 127]. If a benzodiazepine is to be discontinued, the clinician should taper the medication gradually, because abrupt withdrawal can lead to rebound anxiety and complications such as hallucinations, seizures, delirium tremens, and, in rare instances, death. A commonly used tapering schedule is a reduction of the benzodiazepine dose by 25% every one to two weeks [125; 127].

Consultation and Referral

It is important to seek consultation or patient referral when input or care from a pain, psychiatry, addiction, or mental health specialist is necessary. Clinicians who prescribe opioids should become familiar with opioid addiction treatment options (including licensed opioid treatment programs for methadone and office-based opioid treatment for buprenorphine) if referral is needed [132].

Ideally, providers should be able to refer patients with active substance abuse who require pain treatment to an addiction professional or specialized program. In reality, these specialized resources are scarce or non-existent in many areas [132]. Therefore, each provider will need to decide whether the risks of continuing opioid treatment while a patient is using illicit drugs outweigh the benefits to the patient in terms of pain control and improved function [160].

Medical Records

As noted, documentation is a necessary aspect of all patient care, but it is of particular importance when opioid prescribing is involved. All clinicians should maintain accurate, complete, and up-to-date medical records, including all written or telephoned prescription orders for opioid analgesics and other controlled substances, all written instructions to the patient for medication use, and the name, telephone number, and address of the patient's pharmacy [132]. Good medical records demonstrate that a service was provided to the patient and that the service was medically necessary. Regardless of the treatment outcome, thorough medical records protect the prescriber.

Patient Education on the Use and Disposal of Opioids

Patients and caregivers should be counseled regarding the safe use and disposal of opioids. As part of its mandatory Risk Evaluation and Mitigation Strategy (REMS) for extended-release/long-acting opioids, the FDA has developed a patient counseling document with information on the patient's specific medications, instructions for emergency situations and incomplete pain control, and warnings not to share medications or take them unprescribed [134]. A copy of this form may be accessed online at https://www.fda.gov/media/114694/download.

When prescribing opioids, clinicians should provide patients with the following information [134]:

- Product-specific information
- Taking the opioid as prescribed
- Importance of dosing regimen adherence, managing missed doses, and prescriber contact if pain is not controlled
- Warning and rationale to never break or chew/crush tablets or cut or tear patches prior to use
- Warning and rationale to avoid other central nervous system depressants, such as sedative-hypnotics, anxiolytics, alcohol, or illicit drugs
- Warning not to abruptly halt or reduce the opioid without physician oversight of safe tapering when discontinuing
- The potential of serious side effects or death
- Risk factors, signs, and symptoms of overdose and opioid-induced respiratory depression, gastrointestinal obstruction, and allergic reactions
- The risks of falls, using heavy machinery, and driving
- Warning and rationale to never share an opioid analgesic
- Rationale for secure opioid storage
- Warning to protect opioids from theft
- Instructions for disposal of unneeded opioids, based on product-specific disposal information

There are no universal recommendations for the proper disposal of unused opioids, and patients are rarely advised of what to do with unused or expired medications [161]. According to the FDA, most medications that are no longer necessary or have expired should be removed from their containers, mixed with undesirable substances (e.g., cat litter, used coffee grounds), and put into an impermeable, nondescript container (e.g., disposable container with a lid or a sealed bag) before throwing in the trash [162]. Any personal information should be obscured or destroyed. The FDA recommends that certain medications, including oxycodone/acetaminophen (Percocet), oxycodone (OxyContin tablets), and transdermal fentanyl (Duragesic Transdermal System), be flushed down the toilet instead of thrown in the trash [162; 163]. The FDA provides a free toolkit of materials (e.g., social media images, fact sheets, posters) to raise awareness of the serious dangers of keeping unused opioid pain medicines in the home and with information about safe disposal of these medicines. The Remove the Risk Outreach toolkit is updated regularly and can be found at https://www.fda.gov/drugs/ensuring-safe-use-medicine/safe-opioid-disposal-remove-risk-outreach-toolkit [163]. Patients should be advised to flush prescription drugs down the toilet only if the label or accompanying patient information specifically instructs doing so.

The American College of Preventive Medicine has established best practices to avoid diversion of unused drugs and educate patients regarding drug disposal [161]:

- Consider writing prescriptions in smaller amounts.
- Educate patients about safe storing and disposal practices.
- Give drug-specific information to patients about the temperature at which they should store their medications. Generally, the bathroom is not the best storage place. It is damp and moist, potentially resulting in potency decrements, and accessible to many people, including children and teens, resulting in potential theft or safety issues.

- Ask patients not to advertise that they are taking these types of medications and to keep their medications secure.
- Refer patients to community "take back" services overseen by law enforcement that collect controlled substances, seal them in plastic bags, and store them in a secure location until they can be incinerated. Contact your state law enforcement agency or visit https://www.dea.gov to determine if a program is available in your area.

Discontinuing Opioid Therapy

The decision to continue or end opioid prescribing should be based on a physician-patient discussion of the anticipated benefits and risks. An opioid should be discontinued with resolution of the pain condition, intolerable side effects, inadequate analgesia, lack of improvement in quality of life despite dose titration, deteriorating function, or significant aberrant medication use [125; 127; 132].

Clinicians should provide patients physically dependent on opioids with a safely structured tapering protocol. Withdrawal is managed by the prescribing physician or referral to an addiction specialist. Patients should be reassured that opioid discontinuation is not the end of treatment; continuation of pain management will be undertaken with other modalities through direct care or referral.

As a side note, cannabis use by patients with chronic pain receiving opioid therapy has traditionally been viewed as a treatment agreement violation that is grounds for termination of opioid therapy. However, some now argue against cannabis use as a rationale for termination or substantial treatment and monitoring changes, especially considering the increasing legalization of medical use at the state level [160].

Considerations for Non-English-Proficient Patients

For patients who are not proficient in English, it is important that information regarding the risks associated with the use of opioids and available resources be provided in their native language, if possible. When there is an obvious disconnect in the communication process between the practitioner and patient due to the patient's lack of proficiency in the English language, an interpreter is required. Interpreters can be a valuable resource to help bridge the communication and cultural gap between patients and practitioners. Interpreters are more than passive agents who translate and transmit information back and forth from party to party. When they are enlisted and treated as part of the interdisciplinary clinical team, they serve as cultural brokers who ultimately enhance the clinical encounter. In any case in which information regarding treatment options and medication/treatment measures are being provided, the use of an interpreter should be considered. Print materials are also available in many languages, and these should be offered whenever necessary.

IDENTIFICATION OF DRUG DIVERSION/SEEKING BEHAVIORS

Which behaviors are most suggestive of an emerging opioid use disorder?

Research has more closely defined the location of prescribed opioid diversion into illicit use in the supply chain from the manufacturer to the distributor, retailer, and the end user (the pain patient). This information carries with it substantial public policy and regulatory implications. The 2021 National Survey on Drug Use and Health asked non-medical users of prescription opioids how they obtained their most recently used drugs [2]. Among persons 12 years of age or older, 39.3% obtained their prescription opioids through a prescription from one doctor (vs. 34.7% in 2019), 33.9% got them from a friend or relative for free, 7.9% bought from a drug dealer or other stranger, and 7.3% bought them from a friend or relative [2]. Less frequent sources included stealing from a friend or relative (3.7%); multiple doctors (3.2%); and theft from a doctor's office, clinic, hospital, or pharmacy (0.7%) (vs. 0.2% in 2009–2010) [2].

As discussed, UDTs can give insight into patients who are misusing opioids. A random sample of UDT results from 800 patients treated for pain at a Veterans Affairs facility found that 25.2% were negative for the prescribed opioid while 19.5% were positive for an illicit drug/unreported opioid [164]. Negative UDT results for the prescribed opioid do not necessarily indicate diversion, but may indicate the patient halted his/her use due to side effects, lack of efficacy, or pain remission. The concern arises over the increasingly stringent climate surrounding clinical decision-making regarding aberrant UDT results and that a negative result for the prescribed opioid or a positive UDT may serve as the pretense to terminate a patient rather than guide him/her into addiction treatment or an alternative pain management program [165].

In addition to aberrant urine screens, there are certain behaviors that are suggestive of an emerging opioid use disorder. The most suggestive behaviors are [160; 166; 167]:

- Selling medications
- Prescription forgery or alteration
- Injecting medications meant for oral use
- Obtaining medications from nonmedical sources
- Resisting medication change despite worsening function or significant negative effects
- Loss of control over alcohol use
- Using illegal drugs or non-prescribed controlled substances
- Recurrent episodes of:
    - Prescription loss or theft
    - Obtaining opioids from other providers in violation of a treatment agreement

  - Unsanctioned dose escalation
  - Running out of medication and requesting early refills

Behaviors with a lower level of evidence for their association with opioid misuse include [160; 166; 167]:

- Aggressive demands for more drug
- Asking for specific medications
- Stockpiling medications during times when pain is less severe
- Using pain medications to treat other symptoms
- Reluctance to decrease opioid dosing once stable
- In the earlier stages of treatment:
  - Increasing medication dosing without provider permission
  - Obtaining prescriptions from sources other than the pain provider
  - Sharing or borrowing similar medications from friends/family

EVIDENCE-BASED PRACTICE RECOMMENDATION

The Institute for Clinical Systems Improvement recommends considering screening patients for substance use disorders when there is an unclear etiology of pain.

(https://www.icsi.org/wp-content/uploads/2019/10/Pain-Interactive-7th-V2-Ed-8.17.pdf. Last accessed April 27, 2023.)

Level of Evidence: Expert Opinion/Consensus Statement

INTERVENTIONS FOR SUSPECTED OR KNOWN ADDICTION OR DRUG DIVERSION

There are a number of actions that prescribers and dispensers can take to prevent or intervene in cases of drug diversion. These actions can be generally categorized based on the various mechanisms of drug diversion.

Prevention is the best approach to addressing drug diversion. As noted, the most common source of nonmedical use of prescribed opioids is from a family member or friend, through sharing, buying, or stealing. To avoid drug sharing among patients, healthcare professionals should educate patients on the dangers of sharing opioids and stress that "doing prescription drugs" is the same as "using street drugs" [161]. In addition, patients should be aware of the many options available to treat chronic pain aside from opioids. To prevent theft, patients should be advised to keep medications in a private place and to refrain from telling others about the medications being used.

Communication among providers and pharmacies can help to avoid inappropriate attainment of prescription drugs through "doctor shopping." Prescribers should keep complete and up-to-date records for all controlled substance prescribing. When possible, electronic medical records should be integrated between pharmacies, hospitals, and managed care organizations [161]. If available, it is also best practice to periodically request a report from the state's prescription reporting program to evaluate the prescribing of opioids to your patients by other providers [161].

When dealing with patients suspected of drug seeking/diversion, first inquire about prescription, over-the-counter, and illicit drug use and perform a thorough examination [161]. Pill counting and/or UDT may be necessary to investigate possible drug misuse. Photo identification or other form of identification and social security number may be required prior to dispensing the drug, with proof of identity documented fully. If a patient is displaying suspicious behaviors, consider prescribing for limited quantities.

If a patient is found to be abusing prescribed opioids, this is considered a violation of the treatment agreement and the clinician must make the decision whether or not to continue the therapeutic relationship. If the relationship is terminated, it must be done ethically and legally. The most significant issue is the risk of patient abandonment, which is defined as ending a relationship with a patient without consideration of continuity of care and without providing notice to the patient. The American Medical Association Code of Ethics states that physicians have an obligation to support continuity of care for their patients. While physicians have the option of withdrawing from a case, they should notify the patient (or authorized decision maker) long enough in advance to permit the patient to secure another physician and facilitate transfer of care when appropriate [168]. Patients may also be given resources and/or recommendations to help them locate a new clinician.

Patients with chronic pain found to have an ongoing substance abuse problem or addiction should be referred to a pain specialist for continued treatment. Theft or loss of controlled substances is reported to the DEA. If drug diversion has occurred, the activity should be documented and a report to law enforcement should be made [169].

COMPLIANCE WITH STATE AND FEDERAL LAWS

Which government agency is responsible for formulating federal standards for the handling of controlled substances?

In response to the rising incidence in prescription opioid abuse, addiction, diversion, and overdose since the late 1990s, the FDA has mandated opioid-specific REMS to reduce the potential negative patient and societal effects of prescribed opioids. Other elements of opioid risk mitigation include FDA partnering with other governmental agencies, state professional licensing boards, and societies of healthcare professionals to help improve prescriber knowledge of appropriate and safe opioid prescribing and safe home storage and disposal of unused medication [153].

Several regulations and programs at the state level have been enacted in an effort to reduce prescription opioid abuse, diversion, and overdose, including [170]:

- Physical examination required prior to prescribing
- Tamper-resistant prescription forms
- Pain clinic regulatory oversight
- Prescription limits
- Prohibition from obtaining controlled substance prescriptions from multiple providers
- Patient identification required before dispensing
- Immunity from prosecution or mitigation at sentencing for individuals seeking assistance during an overdose

Controlled Substances Laws/Rules

The DEA is responsible for formulating federal standards for the handling of controlled substances. In 2011, the DEA began requiring every state to implement electronic databases that track prescribing habits, referred to as PDMPs. Specific policies regarding controlled substances are administered at the state level [171].

According to the DEA, drugs, substances, and certain chemicals used to make drugs are classified into five distinct categories or schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential [172]. The abuse rate is a determinate factor in the scheduling of the drug; for example, Schedule I drugs are considered the most dangerous class of drugs with a high potential for abuse and potentially severe psychologic and/or physical dependence.

State-Specific Laws and Rules

Most states have established laws and rules governing the prescribing and dispensing of opioid analgesics. It is each prescriber's responsibility to have knowledge of and adhere to the laws and rules of the state in which he or she prescribes.

CONCLUSION

Substance use disorders are associated with serious morbidity and mortality, and advances in the understanding of these disorders have led to the development of effective treatments. More recently, the abuse of prescription opioids has become considerably more widespread, fueled in part by the availability of such drugs over the Internet. Medical, mental health, and other healthcare professionals in a variety of settings may encounter patients with comorbid substance use disorders and pain. The knowledge gained from the contents of this course can greatly assist the healthcare professional in identifying, treating, and providing an appropriate referral to patients with substance use disorders while also addressing pain management needs.

Customer Information/Evaluation insert located between pages 16–17.

Course Availability List

These courses may be ordered by mail on the Customer Information form located between pages 16–17.
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POSTOPERATIVE COMPLICATIONS

UPDATE

#30764 • 15 ANCC / 1 Pharm Hour

Book By Mail – $98 • ONLINE – $90

Purpose: The purpose of this course is to provide nurses and all allied health professionals who care for postsurgical patients the knowledge necessary to recognize and manage common postoperative complications, improving patient care and outcomes.
Faculty: Susan Engman Lazear, RN, MN
Audience: This course is designed for all nurses and allied professionals involved in the care of patients who undergo surgical procedures, especially those who work in the preoperative area, the operating room, or the postanesthesia unit in hospitals or free-standing surgical centers.
Additional Approval: AACN Synergy CERP Category A, CCMC

CHILDHOOD OBESITY: IMPACT ON HEALTH CARE

#32014 • 5 ANCC / 1 Pharm Hour

Book By Mail – $38 • ONLINE – $30

Purpose: The impact of childhood obesity on an already stressed healthcare system is high and is estimated to rise as the diagnoses of comorbid conditions continue to occur at a younger age. The purpose of this course is to provide nurses with the information necessary to improve the care of children and adolescents who are overweight or obese.
Faculty: Diane Thompson, RN, MSN, CDE, CLNC
Audience: This course is designed for nurses in all practice settings with a desire to better understand the issues facing obese children and their families and the impact of childhood obesity on national and global health care.
Additional Approval: AACN Synergy CERP Category A, CCMC

WOMEN AND CORONARY HEART DISEASE

UPDATE

#33224 • 15 ANCC / 5 Pharm Hours

Book By Mail – $98 • ONLINE – $90

Purpose: The purpose of this course is to identify the unique challenges that face women with heart disease, including prevention, diagnosis, and treatment.
Faculty: Margo A. Halm, RN, PhD, NEA-BC
Audience: This course is designed for all nurses in family practice or medical/surgical areas, especially critical care or cardiac units.
Additional Approval: AACN Synergy CERP Category A, CCMC

PRESSURE INJURIES AND SKIN CARE

UPDATE

#34344 • 5 ANCC Hours

Book By Mail – $38 • ONLINE – $30

Purpose: The purpose of this course is to provide nurses with the information necessary to accurately identify, treat, and manage skin breakdown (pressure ulcers), thereby improving patient outcomes and quality of life.
Faculty: Maryam Mamou, BSN, RN, CRRN, CWOCN
Audience: This course is designed for nurses in all practice settings, particularly those caring for patients at high risk for developing pressure injuries.
Additional Approval: AACN Synergy CERP Category A, CCMC

MULTIMODAL PHARMACOTHERAPY FOR PAIN MANAGEMENT

Pain Mgmt

#35270 • 5 ANCC / 5 Pharm Hours

Book By Mail – $38 • ONLINE – $30

Purpose: The purpose of this course is to provide healthcare providers with a clear understanding of the concept of multimodal pharmacotherapy for pain relief, including available classes of analgesics.
Faculty: Richard E. Haas, BSN, MSN, EdM, PhD, CRNA (Retired), LTC US Army Nurse Corps (Retired)
Audience: This course is designed for nurses involved in the care of patients with pain.
Additional Approval: AACN Synergy CERP Category A, CCMC
Special Approval: This course meets the Texas APRN requirements for pain management and opioid/controlled substance education.

ETHICAL DECISION MAKING

UPDATE

#37074 • 15 ANCC Hours

Book By Mail – $98 • ONLINE – $90

Purpose: The purpose of this course is to assist healthcare professionals to define the predominant ethical theories and principles used in health care, determine any legal and regulatory implications, and in collaboration with their colleagues and patients/clients, make effective decisions that determine the appropriate course of treatment, or refusal of such, for and with those for whom they care.
Faculty: Michele Nichols, RN, BSN, MA
Audience: This course is designed for all nurses and allied healthcare professionals.
Additional Approval: AACN Synergy CERP Category B, CCMC

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Course Availability List *(Cont'd)*

FORENSIC NURSING: AN OVERVIEW

#37104 • 2 ANCC HOURS

Forensic Nursing

BOOK BY MAIL – $23 • ONLINE – $15

Purpose: Forensic nurses are an important link between the medical and legal worlds. The purpose of this course is to inform nursing professionals about forensic evidence collection and documentation, being mindful of preserving evidence while managing critically injured patients, and making referrals to or requesting the assistance of forensic specialists.

Faculty: Michelle Booth, RN, BSN

Audience: This course is designed for all nurses involved in the assessment and care victims, including sexual assault nurse examiners and other forensic nursing specialists.

Additional Approval: AACN Synergy CERP Category A

Special Approval: This course meets the Texas requirement for 2 hours of education in the area of forensic evidence collection for those who work in an emergency room setting or treat sexual assault survivors.

SMOKING AND SECONDHAND SMOKE

#91784 • 10 ANCC / 5 PHARM HOURS

BOOK BY MAIL – $68 • ONLINE – $60

Purpose: The purpose of this course is to provide physicians, nurses, behavioral health professionals, and other members of the interdisciplinary team with a formal educational opportunity that will address the impact of tobacco smoking and secondhand exposure in public health and disease as well as interventions to promote smoking cessation among their patients.

Faculty: Mark S. Gold, MD, DFASAM, DLFAPA

Audience: This course is designed for physicians, nurses, and other healthcare professionals who may intervene to stop patients from smoking.

Additional Approval: AACN Synergy CERP Category A, CCMC

CANCER SCREENING

#91993 • 10 ANCC HOURS

BOOK BY MAIL – $68 • ONLINE – $60

Purpose: The purpose of this course is to concisely provide the evidence-based guidelines and recommendations for cancer screening in order to improve healthcare professionals' adherence and ultimately increase overall screening rates, leading to improvements in public health.

Faculty: Lori L. Alexander, MTPW, ELS, MWC

Audience: This course is designed for physicians, physician assistants, and nurses who may intervene to improve cancer screening rates.

Additional Approval: AACN Synergy CERP Category A

MATERNAL HEALTH DISPARITIES

#93010 • 4 ANCC HOURS

NEW!

BOOK BY MAIL – $32 • ONLINE – $24

Purpose: The purpose of this course is to provide healthcare providers with the knowledge and skills necessary to improve maternal outcomes in all races, ethnicities, and marginalized groups.

Faculty: Mary Franks, MSN, APRN, FNP-C

Audience: This course is designed for all healthcare providers who may intervene to improve peripartum and postpartum health care and reduce health disparities.

Additional Approval: AACN Synergy CERP Category B

PHARMACOLOGIC AND MEDICAL ADVANCES IN OBESITY MANAGEMENT

#94280 • 15 ANCC / 12 PHARM HOURS

NEW!

BOOK BY MAIL – $98 • ONLINE – $90

Purpose: The purpose of this course is to ensure that providers have current and accurate knowledge regarding the available pharmacologic and surgical options to improve outcomes among their patients, with the ultimate goal of improving patient care and outcomes.

Faculty: Mark Rose, BS, MA, LP

Audience: This course is designed for all physicians, nurses, and allied professionals involved in the care of patients who are overweight or obese.

Additional Approval: AACN Synergy CERP Category A

AUTOIMMUNE DISEASES

#94454 • 15 ANCC / 10 PHARM HOURS

UPDATE

BOOK BY MAIL – $98 • ONLINE – $90

Purpose: The purpose of this course is to provide healthcare professionals with the information necessary to diagnose and treat the most common autoimmune disorders according to evidence-based or guideline-endorsed recommendations in order to improve patient quality of life.

Faculty: Lori L. Alexander, MTPW, ELS, MWC; John M. Leonard, MD

Audience: This course is designed for physicians, physician assistants, nurses, and other healthcare professionals involved in the diagnosis, treatment, and care of patients with autoimmune diseases.

Additional Approval: AACN Synergy CERP Category A, CCMC

MANAGING DRUG INTERACTIONS WITH DIRECT ORAL ANTICOAGULANTS

#95010 • 1 ANCC / 1 PHARM HOUR

NEW!

BOOK BY MAIL – $23 • ONLINE – $15

Purpose: The purpose of this course is to provide prescribers and other healthcare professionals with the knowledge and skills necessary to identify and act to avoid or address drug-drug interactions that occur in patients taking direct oral anticoagulants.

Faculty: Jeff Langford, PharmD, BCPS-AQ Cardiology, BCCP

Audience: This course is designed for physicians, physician assistants, and nurses involved in the care of patients who require anticoagulation therapy.

Additional Approval: AACN Synergy CERP Category A

OPIOID SAFETY: BALANCING BENEFITS AND RISKS

#95500 • 5 ANCC / 5 PHARM HOURS

Opioid/ Controlled Substance

BOOK BY MAIL – $38 • ONLINE – $30

Purpose: The purpose of this course is to provide clinicians who prescribe or distribute opioids with an appreciation for the complexities of opioid prescribing and the dual risks of litigation due to inadequate pain control and drug diversion or misuse in order to provide the best possible patient care and to prevent a growing social problem.

Faculty: Mark Rose, BS, MA, LP

Audience: This course is designed for all physicians, osteopaths, physician assistants, pharmacy professionals, and nurses who may alter prescribing and/or dispensing practices to ensure safe opioid use.

Additional Approval: AACN Synergy CERP Category A

Special Approval: This course is designed to meet the requirements for opioid/controlled substance education.

Prices are subject to change.
Visit www.NetCE.com for a list of current prices.

Course Availability List *(Cont'd)*

SUICIDE ASSESSMENT AND PREVENTION

#96442 • 6 ANCC Hours

Book By Mail – $44 • ONLINE – $36

Purpose: The purpose of this course is to provide health and mental health professionals with an appreciation of the impact of depression and suicide on patient health as well as the skills necessary to identify and intervene for patients at risk for suicide.

Faculty: Mark Rose, BS, MA, LP

Audience: This course is designed for physicians, nurses, pharmacists, and other healthcare professionals who may identify persons at risk for suicide and intervene to prevent or manage suicidality.

Additional Approval: AACN Synergy CERP Category A, CCMC

PSYCHEDELIC MEDICINE AND INTERVENTIONAL PSYCHIATRY

NEW!

#96790 • 10 ANCC / 8 Pharm Hours

Book By Mail – $68 • ONLINE – $60

Purpose: The purpose of this course is to provide medical and mental health professionals with the knowledge and skills necessary to effectively treat mental disorders using emerging psychedelic and interventional techniques.

Faculty: Mark S. Gold, MD, DFASAM, DLFAPA

Audience: The course is designed for all members of the interprofessional team, including physicians, physician assistants, nurses, and mental health professionals, involved in caring for patients with mental disorders resistant to traditional treatment approaches.

Additional Approval: AACN Synergy CERP Category A, CCMC

INTERCULTURAL COMPETENCE AND PATIENT-CENTERED CARE

NEW!

#97510 • 4 ANCC Hours

Book By Mail – $32 • ONLINE – $24

Purpose: The purpose of this course is to provide members of the interprofessional healthcare team with the knowledge, skills, and strategies necessary to provide culturally competent and responsive care to all patients.

Faculty: Alice Yick Flanagan, PhD, MSW

Audience: This course is designed for all members of the interprofessional healthcare team.

Additional Approval: AACN Synergy CERP Category B

THE SCOOP ON COLLAGEN

NEW!

#98070 • 1.5 ANCC Hours

Book By Mail – $23 • ONLINE – $15

Purpose: The purpose of this course is to provide healthcare professionals in all practice settings the knowledge necessary to increase their understanding of the various collagen products.

Faculty: Chelsey McIntyre, PharmD

Audience: This course is designed for healthcare professionals whose patients are taking or are interested in taking collagen products.

Additional Approval: AACN Synergy CERP Category A

ANEMIA IN THE ELDERLY

Geriatrics

#99084 • 5 ANCC / 2 Pharm Hours

Book By Mail – $38 • ONLINE – $30

Purpose: The purpose of this course is to provide healthcare providers with the knowledge and tools necessary to identify anemia early and respond appropriately. Better health outcomes for the geriatric population will result from an increase in evidence-based clinical practices.

Faculty: Susan Waterbury, MSN, FNP-BC, ACHPN

Audience: This course is designed for physicians, physician assistants, nurses, and other healthcare professionals involved in the care of elderly patients.

Additional Approval: AACN Synergy CERP Category A, CCMC

Special Approval: This course fulfills the Texas requirement for 2 hours of education relating to geriatrics for those whose practice includes a geriatric population.

AGING AND LONG-TERM CARE

Geriatrics

#99354 • 3 ANCC Hours

Book By Mail – $26 • ONLINE – $18

Purpose: The purpose of this course is to provide the tools necessary for social workers, counselors, mental health professionals, and allied health professionals to successfully assess and care for older adults, an increasingly large portion of the U.S. population.

Faculty: Alice Yick Flanagan, PhD, MSW

Audience: This course is designed for nurses, social workers, counselors, mental health professionals, and allied health professionals involved in the care of older adults.

Additional Approval: AACN Synergy CERP Category B, CCMC

Special Approval: This course fulfills the Texas requirement for 2 hours of education relating to geriatrics for those whose practice includes a geriatric population.

Prices are subject to change.
Visit www.NetCE.com for a list of current prices.

ATTENTION TEXAS NURSES,

You may have some questions about your continuing education requirements. We're here to help!

Texas nurses may choose to meet their continuing competency requirement for license renewal by completing 20 contact hours of approved continuing nursing education (CNE). Nurses who choose to complete 20 contact hours must complete courses within their current area of practice. If you do not have a current area of practice, you must refer to your prior area of practice.

HUMAN TRAFFICKING

Any nurse who provides direct patient care must complete a human trafficking prevention course that is approved by the Texas Health and Human Services Commission (HHSC) every renewal period. NetCE's featured course #97471 Human Trafficking and Exploitation: The Texas Requirement has been approved by the Texas HHSC to meet this requirement. The course is featured on page 19.

GERIATRIC REQUIREMENT

As part of the 20 contact hours, nurses whose practice includes older adult or geriatric populations must complete at least two contact hours of CNE in geriatrics every two-year renewal cycle. Our course #97770 Counseling Patients at the End of Life meets this requirement and is featured in this booklet on page 36.

NURSING JURISPRUDENCE AND ETHICS

All nurses are required to complete two contact hours in Nursing Jurisprudence and Nursing Ethics every third renewal cycle. These two hours may be included in the 20 hours of required CNE. Our course #31133 Texas Nursing Jurisprudence and Ethics meets this requirement and is featured in this booklet on page 1.

FORENSIC EVIDENCE COLLECTION

Nurses employed in an emergency room setting or who treat sexual assault survivors must complete a one-time requirement of two hours of CNE relating to forensic evidence collection. Our course #37104 Forensic Nursing: An Overview will meet this requirement and is advertised in this booklet on page 78.

PAIN MANAGEMENT/OPIOIDS/ CONTROLLED SUBSTANCES

APRNs authorized to receive information from the Prescription Monitoring Program (PMP) licensed prior to September 1, 2020 must complete two (2) contact hours related to approved procedures for prescribing and monitoring controlled substances. APRNs licensed after September 1, 2020 and authorized to receive information from the PMP must fulfill the requirement within one year of initial licensure. Our course #95300 Substance Use Disorders and Pain Management will fulfill this requirement and is featured in this booklet on page 52.

APRNs who have entered into a prescriptive authority agreement authorizing the prescribing of opioids must complete two (2) contact hours annually (4 contact hours every licensing period) regarding the safe and effective pain management related to the prescription of opioids and other controlled substances. This must include education regarding reasonable standards of care, the identification of drug-seeking behavior in patients, and effectively communicating with patients regarding the prescription of an opioid or other controlled substance. Our course #95300 Substance Use Disorders and Pain Management will fulfill this requirement and is featured in this booklet on page 52.

DESIGN A DEAL, ALL ACCESS, AND PRACTICE-SPECIFIC ONLINE SPECIALS

NetCE also gives you options with our practice-specific online specials in Geriatrics, Advanced Practice Nursing, Pediatrics, Wound Management, Pharmacology, Trauma, and Oncology. Our online Design A Deal option lets you create your own special offer based on the number of hours you need. Select from our entire library of courses for one low price at www.NetCE.com/Design. If you need even more hours, try All Access CE for One Year starting at only $85. You'll have access to over 1,700 hours of CE, including special offers and state-required courses. Go to www.NetCE.com/NurseUnlimited to get started!

For more information about your license renewal requirements, contact the Texas Board of Nursing at (512) 305-7400.

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$63

ENCLOSED SPECIAL OFFER: 22 HOURS

You may complete ALL five of these courses for a maximum payment of $37 (or pay the individual course price).

✓	Course #	Course Title / Contact Hours	Price
	31133	Texas Nursing Jurisprudence and Ethics / 2 Contact Hours	$15
	90120	Pulmonary Embolism / 2 Contact Hours	$15
	97471	Human Trafficking and Exploitation: The Texas Requirement / 5 Contact Hours	$30
	97770	Counseling Patients at the End of Life / 5 Contact Hours	$30
	95300	Substance Use Disorders and Pain Management / 8 Contact Hours	$48

Additional Courses Available by Mail (ACCESS ONLINE FOR A DISCOUNT!)
Payment must accompany this form. To order by phone, please have your credit card ready.

✓	Course #	Course Title / Contact Hours	Price	✓	Course #	Course Title / Contact Hours	Price
☐	30764	Postoperative Complications / 15	$98	☐	94280	Pharmacologic & Medical Advances in Obesity Mgmt / 15	$98
☐	32014	Childhood Obesity: Impact on Health Care / 5	$38	☐	94454	Autoimmune Diseases / 15	$98
☐	33224	Women and Coronary Heart Disease / 15	$98	☐	95010	Managing Drug Interactions w/ Direct Oral Anticoagulants / 1	$23
☐	34344	Pressure Injuries and Skin Care / 5	$38	☐	95500	Opioid Safety: Balancing Benefits and Risks / 5	$38
☐	35270	Multimodal Pharmacotherapy for Pain Mgmt / 5	$38	☐	96442	Suicide Assessment and Prevention / 6	$44
☐	37074	Ethical Decision Making / 15	$98	☐	96790	Psychedelic Medicine & Interventional Psychiatry / 10	$68
☐	37104	Forensic Nursing: An Overview / 2	$23	☐	97510	Intercultural Competence & Patient-Centered Care / 4	$32
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☐	91993	Cancer Screening / 10	$68	☐	99084	Anemia in the Elderly / 5	$38
☐	93010	Maternal Health Disparities / 4	$32	☐	99354	Aging and Long-Term Care / 3	$26

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Evaluation

(Completion of this form is mandatory)

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To receive continuing education credit, completion of this Evaluation is mandatory.
Please answer all of the following questions and provide your signature at the bottom of this page.
Your postmark or facsimile date will be used as your completion date.

Please read the following questions and choose the most appropriate answer for each course completed.

1. Was the course content new or review?
2. How much time did you spend on this activity?
3. Would you recommend this course to your peers?
4. Did the course content support the stated course objective?
5. Did the course content demonstrate the author's knowledge of the subject?
6. Was the course content free of bias?
7. Before completing the course, did you identify the necessity for education on the topic to improve your nursing practice?
8. Have you achieved all of the stated learning objectives of this course?
9. Has what you think or feel about this topic changed?
10. Did study questions throughout the course promote recall of learning objectives?
11. Did evidence-based practice recommendations assist in determining the validity or relevance of the information?
12. Are you more confident in your ability to provide nursing care after completing this course?
13. Do you plan to make changes in your nursing practice as a result of this course content?

	#31133 TX Nursing Jurisprudence 2 Contact Hours	**#90120** Pulmonary Embolism 2 Contact Hours	**#97471** TX Human Trafficking 5 Contact Hours	**#97770** Counseling Patients at the EOL 5 Contact Hours	**#95300** Substance Use Disorders 8 Contact Hours
1.	☐ New ☐ Review	☐ New ☐ Review	☐ New ☐ Review	☐ New ☐ Review	☐ New ☐ Review
2.	_____ Hours	_____ Hours	_____ Hours	_____ Hours	_____ Hours
3.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
11.	☒ N/A	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
12.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
13.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

#31133 Texas Nursing Jurisprudence and Ethics — If you answered yes to question #13, how specifically will this activity enhance your role as a member of the interprofessional team? ______________________________

#90120 Pulmonary Embolism — If you answered yes to question #13, how specifically will this activity enhance your role as a member of the interprofessional team? ______________________________

#97471 Human Trafficking and Exploitation: The Texas Requirement — If you answered yes to question #13, how specifically will this activity enhance your role as a member of the interprofessional team? ______________________________

#97770 Counseling Patients at the End of Life — If you answered yes to question #13, how specifically will this activity enhance your role as a member of the interprofessional team? ______________________________

#95300 Substance Use Disorders and Pain Management — If you answered yes to question #13, how specifically will this activity enhance your role as a member of the interprofessional team? ______________________________

May we contact you later regarding your comments about these activities? ☐ Yes ☐ No

I have read the course(s) and completed the Evaluation(s) in full.
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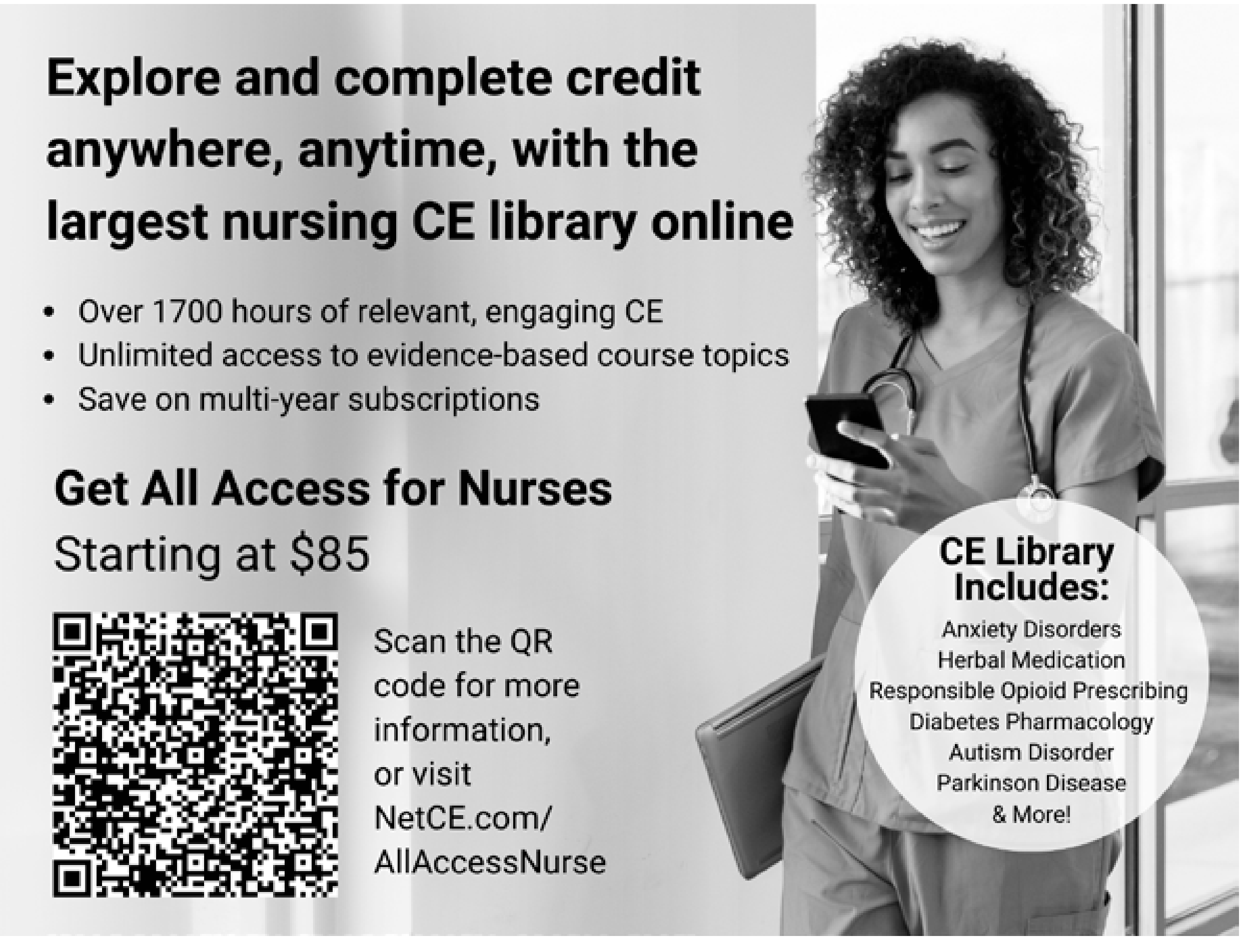
Signature required to receive continuing education credit.



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