Doug Ducey
Governor

Joey Ridenour
Executive Director

Arizona State Board of Nursing
1740 W Adams Street, Suite 2000
Phoenix, AZ 85007
Phone (602) 771-7800 | Website: www.azbn.gov

An advisory opinion adopted by AZBN is an interpretation of what the law requires. While an advisory opinion is not law, it is more than a recommendation. In other words, an advisory opinion is an official opinion of AZBN regarding the practice of nursing as it relates to the functions of nursing. Facility policies may restrict practice further in their setting and/or require additional expectations related to competency, validation, training, and supervision to assure the safety of their patient population and or decrease risk.

OPINION: The Use of Controlled Substances for the Treatment of Chronic Pain
APPROVED DATE: 9/24/2004
REVISED DATE: 01/2009; 07/2012; 01/2017; 05/2020
ORIGINATING COMMITTEE: APRN ADVISORY COMMITTEE
Within the Scope of Practice of ___ LPN ___ RN _X_ RNP

ADVISORY OPINION
THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF CHRONIC PAIN

STATEMENT OF SCOPE

References to Registered Nurse Practitioner (RNP) and Certified Nurse Midwife prescribers will be described by "APRN" or "clinician" in the following document. As of 2020 Certified Nurse Anesthetist (CRNA) & Clinical Nurse Specialist (CNS) cannot prescribe controlled substances in Arizona.

It is within the Scope of Practice of the Registered Nurse Practitioner (RNP) and the Certified Nurse Midwife (CNM) to prescribe controlled substances for the population focus in which the nurse is certified and if the APRN has obtained prescribing and dispensing authority from the Board of Nursing, and is granted authority from the U.S. Drug Enforcement Agency. An APRN shall only provide health care services within the nurse practitioner's scope of practice for which the APRN is educationally prepared and for which competency has been established and maintained. Prior to prescribing opioids for chronic pain, the APRN shall complete at least 2 hours of continuing education in the use of opioid therapy for chronic pain. With each license renewal cycle, the APRN must complete 3 hours of continuing education that is opioid, substance use disorder, or addiction related.

I. GUIDELINES FOR THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF CHRONIC PAIN

For the purposes of these guidelines, chronic pain is defined as: A pain state, which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease. When efforts to remove the cause of pain or to treat it with appropriate referrals and/or other modalities have been unsuccessful, the prescribing of controlled substances for patients with chronic non-cancer pain may be beneficial.

A. Patient Evaluation

Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh the risks to the patient. Opioid therapy should be combined with non-pharmacologic therapy. Prior to prescribing long-term opioid medications for chronic non-malignant pain, it is standard of care for an APRN to conduct an appropriate evaluation of the pain problem and identify the pain generator. This evaluation includes the APRN taking a comprehensive pain history, reviewing the patient's medical records (including from previous provider, if applicable), conducting a targeted physical exam, taking a drug history including verification of current prescriptions and considering concomitant medical/psychiatric problems that may impact pain management. Each patient's treatment plan should be individualized, and include consideration of a multidisciplinary approach/collaboration with other medical experts, as appropriate and risk assessment for use of chronic opioid therapy (COT).

Pain assessment should occur during initial evaluation, after each new report of pain, at appropriate intervals after each pharmacological intervention, and at regular intervals during treatment. The evaluation should include: A medical history and physical examination conducted and documented in the medical record, diagnostic evaluations such as blood test; radiologic exams, neurophysiologic exams, and psychological evaluations as indicated; the pain source, nature, and intensity/severity of the pain, current and past treatments for pain, underlying or coexisting diseases, or conditions, the effect of the pain on physical and psychological function and history of substance abuse; document the presence of one or more recognized indications for the use of a controlled substance; should be corroborated by reviewing the patient's health care records and/or speaking with the patient's former health care providers and documented in the medical record.

B. Psycho-Social Assessment

Evaluation of the chronic pain patient should include a psycho-social assessment, which may include, but is not limited to the patient's understanding of the diagnosis, expectations about pain relief and pain management methods, concerns regarding the use of controlled substances, and coping mechanisms for pain. Additionally, an assessment of changes in mood, which have occurred secondary to pain (i.e., anxiety, depression); and the meaning of pain to the patient and his/her family.

C. Exclusion Criteria

Exclusion criteria for controlled substance management by the APRN may include: A history of chemical dependency, major psychiatric disorder, unstable social situation, or a current or planned pregnancy. These patients should be referred to the appropriate specialists.

D. Establish And Measure Goals For Pain And Function

Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain/function and should consider how opioid therapy will be discontinued if benefits do not outweigh the risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

E. Discuss Benefits, Risks, And Availability Of Non-Opioid Therapies With Patient

Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy. The patient shall be counseled on the importance of regular visits, taking medications as prescribed and the impact of recreational drug use and avoiding the use of multiple pharmacies and providers for prescriptions. The APRN and the patient shall enter into a written pain treatment agreement that specifically states the patient's responsibilities for the treatment plan and the consequences of breaching the agreement treatment plan.

F. Consultation

The APRN may refer the patient as necessary for additional evaluation to achieve treatment objectives. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation, and consultation with or referral to an expert in the management of such patients, such as an addictionologist.

G. Immediate Release

When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

H. When Opioids Are Started, Clinicians Should Prescribe Lowest Effective Dosage

Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day. In the outpatient setting, when increasing a dosage to ≥90 MME/day, and in accordance with the Arizona Opioid Epidemic Act, the APRN must document consultation with a physician who is board certified in pain management or consult with Opioid Assistance Referral (OAR) line

staff. Additionally, justification to titrate dosage to ≥90 MME/day must be discussed with the patient and documented in the chart.

I. 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 and must limit prescription to 5 days, or if post operative, limit it to 14 days. Some exceptions include patients being treated for severe burns, trauma unrelated to surgery, cancer and/or palliative or hospice care, patients in skilled care facilities and neonates being weaned off opioids post delivery, pursuant to the Arizona Opioid Epidemic Act.

J. Evaluate Benefits And Risk Of Continued Therapy

Clinicians should evaluate benefits and risks with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate the benefits and risks of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh the risks of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

K. Assess Risk and Address Harms of Opioid Use

Before starting and at least every 3 months during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present. Clinicians must prescribe naloxone to patients on > 90MME per day.

L. Review Of Controlled Substance Prescription Monitoring Program (CSPMP)

A.R.S. § 36-2606 requires each medical practitioner who is licensed under Title 32 and who possesses a DEA license to register with the CSPMP through the Arizona State Board of Pharmacy . Each DEA license should have an associated registration. Clinicians shall review the patient's history of controlled substance prescriptions using the (CSPMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians must do a 12 month review of the patient's CSPMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

M. Urine Drug Testing

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and periodically to assess for adherence to prescribed medications as well as presence of other controlled prescription drugs and illicit drugs.

N. Avoid Opioids And Benzodiazepines Concurrently

Concurrent use or abuse of benzodiazepines and opioids puts patients at significant risk of fatal overdose. Written treatment agreements should be utilized to clarify treatment expectations and to specifically educate about the risk for overdose including when opioids and benzodiazepines are combined. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

O. Evidence-Based Treatment

Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder. APRNs must complete the required education and hold a federal (SAMHSA) waiver to prescribe buprenorphine for Opioid Use Disorder (OUD). Methadone must be dispensed or administered in a federally (SAMSHA) approved opioid treatment program (OTP). Clinicians are not allowed to prescribe methadone for OUD in the outpatient setting.

P. Documentation

The RNP shall document the following, as applicable:

1. The health history and physical examination;
2. Diagnostic, therapeutic, and laboratory results;
3. Diagnosis; should include the pain source
4. Evaluations and consultations;
5. Treatment objectives; including functional goals
6. Discussion of risks and benefits;
7. Treatments;
8. Medications (including date, type, dosage, and quantity prescribed);
9. Instructions and agreements;
10. Initial assessment and re-assessment of the pain and efficacy of treatment with rationale for any dosage changes, such as improved or decreased patient function, and patient non-compliance;
11. Whether-or-not the patient is a candidate for controlled substance medications, based on the provider's safety and control assessment, including mandatory review of CSPMP.

Q. Counting and Destroying Medication

The APRN may request to see and count a patient’s medication to assist in determining if the patient is taking the medication as prescribed. The patient should display and count the medication in front of the clinician. Under no circumstances should the APRN touch a patient’s controlled substances. If the medication must be destroyed, it should be

destroyed in accordance with federal guidelines. The APRN should document this fact in the patient record.

R. Post-Dated Prescriptions

Post-dated prescriptions are illegal in the State of Arizona. Therefore, APRNs may not issue post-dated prescriptions. Multiple prescriptions can be provided to the patient complying with the DEA regulations.

S. Referral of Patients with Active Substance Abuse Problems

Patients discovered to have an active substance abuse problem should be referred to either a detoxification and rehabilitation program or to an appropriate maintenance program for substance use disorder (SUD).

T. Assessment For Aberrant Behaviors

Common behaviors in misuse or abuse include multiple prescribers, multiple pharmacies, frequent provider visits, escalating doses and large quantities, high Morphine Milligram Equivalents (MME), early refills, lost or stolen prescriptions, abnormal drug screens/tests, combined controlled substance cocktails, sharing of medications, fraudulent demographics, requesting of specific medications, uninterested in diagnosis or alternative treatments, refusing tests repeatedly, missed follow-up appointments, absence of objective findings, high scores on validated screening tool such as the opioid risk tool (ORT), symptom magnification, inconsistency or textbook presentations. When aberrant behaviors are detected, documentation in the medical record should address the behaviors and future consequences as mentioned to the patient.

U. APRNs May Prescribe Methadone For Pain Management Only

Methadone should only be prescribed by healthcare professionals knowledgeable in the use of this potent opioid for chronic pain management, its proper dosing and titration, risks and benefits of its use including drug:drug interactions, therapeutic effects and risks of serious adverse effects including death. Prior to prescribing methadone, the clinician should have at least 2 continuing education hours completed on prescribing methadone for chronic pain. APRNs may NOT prescribe methadone for OUD.

V. Universal Precautions

The application of "universal precautions" in the initial assessment and treatment of a patient may reduce the risk of accidental overdose, abuse, and misuse.

10 Recommended Steps in Universal Precautions

1. Diagnosis. Identify the pathophysiology for the pain. Identify the pain generator through appropriate diagnostic imaging and other testing.
2. Psychological assessment. Psychological screening including risk of addictive disorders, depression, and anxiety; positive findings may require referral to a specialist.

3. Informed consent. Discuss the risks and benefits of opiate therapy, including side effects and risk of addiction.
4. Treatment agreement. This agreement details the conditions under which the opioid will be continued or discontinued. Both the provider and patient should agree on the contents prior to entering into a long-term opioid treatment plan. The agreement should be reviewed & signed with the patient annually.
5. Pre and post intervention assessment of pain level and function, using the same assessment tool each time if possible. Pain scores and level of functionality should be recorded in the medical record to support continuation of therapy.
6. Appropriate trial of opioid therapy with or without adjunctive medication. If no improvement, the treatment should be titrated down and discontinued.
7. Reassessment of pain score and level of function. Reassessment should be completed at each visit and support the need for continued treatment.
8. Regularly assess the "A's" of pain medicine. Routine assessment of **A**nalgesia, **A**ctivities of daily living, **A**dverse side effects, **A**berrant drug-taking behaviors. **A**dherence (urine toxicology) and **A**ffect (observed mood), support the need for continued therapy.
9. Periodically review pain diagnosis and comorbid conditions, including addictive disorders. Refer to a specialist if underlying addiction disorder or aberrant behaviors are present.
10. Documentation. Complete and accurate documentation of the initial and each follow up visit. Documentation of a physical assessment should be completed initially and with each dosage adjustment.

II. COMPLIANCE WITH LAWS AND REGULATIONS

A. Prescribing Controlled Substances

To prescribe controlled substances, APRNs must comply with all applicable laws, including the following:

1. Possess a valid current RN license and certification as an APRN with prescribing and dispensing authority in the State of Arizona;
2. Possess a valid and current controlled substances Drug Enforcement Administration registration for the schedules being prescribed; and
3. Comply with A.A.C. R4-19-511 and R4-19-512, and changes in A.R.S. chapter 32, sections 1606 and 1706 from the Opioid Epidemic Act of 2018

B. Dispensing Controlled Substances

1. To dispense controlled substances, RNPs must comply with all applicable laws, including the following:
2. Possess a valid current RN license and certification as an RNP or CNM with prescribing and dispensing authority in the State of Arizona;
3. Possess a valid and current controlled substances Drug Enforcement Administration registration for the schedules being dispensed;

4. Comply with A.A.C. R4-19-511, R4-19-512 and R4-19-513; and Opioid Epidemic Act of 2018
5. Comply with 22 CFR 1306.07(a) if controlled substances are dispensed for detoxification.

III. PRESCRIBING AND DISPENSING OPIOID ANTAGONIST; IMMUNITY; GOOD FAITH STATEMENT

1. APRNs may directly or by a standing order prescribe or dispense naloxone hydrochloride or any other opioid antagonist that is approved by the United States Food and Drug Administration for use according to the protocol specified by the APRNs to a person who is at risk of experiencing an opioid-related overdose, to a family member of that person, to a community organization that provides services to persons who are at risk of an opioid related overdose or to any other person who is in a position to assist a person who is at risk of experiencing an opioid related overdose.
2. Clinicians who prescribe or dispense naloxone hydrochloride or any other opioid antagonist pursuant to this section, shall instruct the individual to whom the opioid antagonist is dispensed to summon emergency services as soon as practicable either before or after administering the opioid antagonist.
3. Except in cases of gross negligence, willful misconduct or intentional wrongdoing, APRNs who in good faith prescribe or dispense an opioid antagonist pursuant to this section are immune from professional liability and criminal prosecution for any decision made, act or omission or injury that results from that act if the APRNs act with reasonable care and in good faith.
4. Before prescribing an opioid antagonist pursuant to this section,APRNs may require the person receiving the prescription, as an indicator of good faith, to provide in writing a factual basis for a reasonable conclusion that the person or entity meets the description of this section of a person or entity who is able to receive an opioid antagonist under this section

IV: PATIENT ABANDONMENT

1. Defined as terminating an established nurse-patient relationship without adequate and reasonable notice. (see AO: Patient Abandonment for more information)
2. If the APRN is not proficient in prescribing the opioid/controlled substance, it is appropriate to provide the patient with a referral to a pain management specialist or another provider who has competency in the area of opioid or opioid use disorder treatment.
3. Documentation in the patient's chart should include rationale and any objective evidence for referring the patient, to include the name and address of the provider or practice of the receiving specialist
4. If the patient exhibits evidence of diversion and/or aberrant behavior, evidence of unstable psychiatric condition or evidence of opioid use disorder, referral to the appropriate agency may be necessary.
5. If the patient violates the signed pain agreement, shows evidence of diversion, refuses to comply with the APRN's plan of care recommendations, or shows evidence of great risk in continuing opioid medication, the APRN may discharge the patient as long as there is clear evidence that the patient was referred to the

appropriate agency or specialist. Documentation of the discussion and who or where the patient was referred should be noted in the patient's chart.

6. Appropriate timeline for transfer of care may depend upon circumstances and resources such as; transportation, insurance coverage, specialty availability to the patient

RATIONALE for Patient Abandonment:

Arizona legislation addressing the opioid crisis includes legal limits on prescribing of CSII opioids, benzodiazepines, barbiturates, sleep hypnotics, muscle relaxants and combinations of these medications. Dosing limits are defined in Statute as well. Some providers are making decisions to stop prescribing controlled substances and referring the patient to a pain specialist. Some clinicians are discharging patients who have been stable on opioid medications. Patient safety is of utmost importance, and the APRN must negotiate the laws and risk/benefits of caring for patients who use opioids chronically.

RATIONALE for Chronic Pain management recommendations:

Controlled substances are high-risk medications with misuse and abuse potential. This advisory opinion is intended to improve understanding among advanced practice nurses about the risks and benefits of opioid therapy for chronic pain, improve the safety and efficacy of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death.

The nurse practitioner or CNM is responsible and accountable to ensure that a patient receives appropriate evidence-based nursing assessment and intervention, which effectively treats the patient's pain and meets the recognized standard of practice and care. "Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances" (Institute of Medicine, 1990).

APRNs who prescribe controlled substances in the treatment of patients with chronic pain are held accountable to current evidence based practice guidelines and to federal and state laws concerning prescribing of Controlled Substances. Guidelines are intended to assist the APRN in the responsible use of controlled substances, including but not limited to: 1) When to initiate or continue opioids for chronic pain; 2) As a guide in making decisions regarding opioid and other controlled drug selections, dosage, duration, follow-up, and discontinuation; and 3) In assessing risk and addressing harms of opioid and other controlled substance use. State and Federal laws are intended to protect clinicians and patients with regard to the escalating opioid crisis.

REFERENCES

Arizona Administrative Code (2016). Professions and Occupations, Chapter 19. Board of Nursing. R4-19-508 Standards Related to Registered Nurse Practitioner Scope of Practice (B) Retrieved from: http://apps.azsos.gov/public_services/Title_04/4-19.pdf

Arizona Administrative Code (2016). Roles and Population Foci of Advanced Practice Registered Nursing. R4-19-501-514. Retrieved from: http://apps.azsos.gov/public_services/Title_04/4-19.pdf

Arizona Board of Nursing 2018 Arizona Board of NursingArizona Board of Nursing. (2018, May 23). Arizona Board of Nursing. Retrieved September 7, 2019, from https://www.azbn.gov/sites/default/files/2018-12/ruleseffectivemay232018.pdf 201909071249089425771 24

Arizona Department of Health Services 2018 Arizona Opioid Prescribing Guidelines, 2018Arizona Department of Health Services. (2018). Arizona Opioid Prescribing Guidelines, 2018. Retrieved from: https://azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opioid-prescribing-guidelines.pdf 201909071202439671471 12

Arizona Revised Statute (2016). Professions and Occupations, Title 32, Chapter 15. Authority: A.R.S. § 32-1601 (20) (a) (i-viii) Registered Nurse Practitioner. Retrieved from: http://www.azleg.gov/viewdocument/?docName=http://www.azleg.gov/ars/32/01601.htm

Arizona Revised Statute (2016) Public Health and Safety, Title 36, Chapter 28, Controlled Substance Prescription Monitoring Program, Article 1, General Provisions. 2601-2610. Retrieved from: http://www.azleg.gov/arsDetail/?title=36

Arizona Revised Statute: Public Health and Safety, Title 36, Chapter 2606, Registration; access; renewal; requirements; mandatory use; annual user satisfaction survey; report; definition. Retrieved from: http://www.azleg.gov/ars/36/02606.htm

Arizona Board of Pharmacy (2013). CSPMP Registration and accessing the data. Retrieved from: https://pharmacypmp.az.gov/

Arizona Opioid Epidemic Act, SB1001 (2018), retrieved from: https://legiscan.com/AZ/text/SB1001/id/1706409/Arizona-2018-SB1001-Engrossed.html

Center for Disease Control [CDC] (2016). CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016 Retrieved from: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

Chowdri, P. (2019). What is Patient Abandonment? Retrieved from: https://www.nolo.com/legal-encyclopedia/what-patient-abandonment.html 20190907123423606974244

Dahn, J. (2016, June). Arizona prescribers and the opioid epidemic primer. Retrieved from: http://www.digitaleditionsonline.com/publication/?i=314598&pre=1#{"issue_id":314598,"page":0}

Drug Enforcement Agency [DEA] (2010). Issuance of Multiple Prescriptions for Schedule II Controlled Substances. Retrieved from: www.deadiversion.usdoj.gov/pubs/manuals/pharm2/pharm_content.htm

Franciullo, G., Fine, P., Adler, J., Ballantyne, J., Davies, P., Donovan, M., Fishbain, D., Foley, K., Fudin, J., Gilson, A., Kelter, Al, Mauskop, A., O'Connor, P., Pasik, S., Pasternak, G., Portenoy, R., Rich, B., Roberts, R., Todd, K., Miaskowski, C. (2009). Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. Journal of Pain, 10(2), 113-130

Health Organizations and the Drug Enforcement Administration, Drug Enforcement Agency (2001). Promoting Pain Relief and Preventing Abuse of Pain Medications: A Critical Balancing Act (A Joint Statement from 21 Health Organizations and the Drug Enforcement Administration, Drug Enforcement Agency. Retrieved from: https://www.deadiversion.usdoj.gov/pubs/advisories/painrelief.pdf

Medlaw 2016 Avoid Patient Abandonment: 8 Tips for TerminationMedlaw. (2016, June 7). Avoid Patient Abandonment: 8 Tips for Termination. Retrieved from: https://www.physiciansweekly.com/avoiding-patient-abandonment-proper-termination/201909071241091022636890

National Drug Intelligence Center (2010). National Prescription Drug Threat Assessment. Retrieved from:

http://www.prnewswire.com/news-releases/national-drug-intelligence-center-releases-national-drug-threat-assessment-2010-89129622.html

Nursing Association of New Brunswick 2016 What is Meant by Patient abandonment?Nursing Association of New Brunswick. (2016). What is Meant by Patient abandonment? Info Nursing, 47(1), 42-42.

White House Drug Policy (2011). Executive Office of the President of the United States. National Drug control Budget: Fiscal Year 2011 Funding Highlights. Retrieved from: www.whitehousedrugpolicy.gov/publications/policy/11budgete/fy11highlight.pdf

US Health and Human Services 2018 SAMSA: Tip 63 Medications for Opioid Use DisorderU.S Health and Human Services. (2018). Tip 63 Pharmacotherapy for Opioid Use Disorder for Healthcare Professionals. Retrieved from: https://store.samhsa.gov/system/files/sma18-5063pt3.pdf

U.S Department of Health and Human Services. (2013). Based on Tip 54 Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders. Retrieved from U.S Department of Health and Human Services Substance Abuse and Mental Health Services Administration. Retrieved from: https://store.samhsa.gov/system/files/sma13-4785.pdf

U.S. Department of Health and Human Services (2019, May). Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations. Retrieved from U. S. Department of Health and Human Services website. Retrieved from: https://www.hhs.gov/ash/advisory-committees/pain/reports/index.html